CONTRACT # _____

Between
The North Carolina Department of Health and Human Services
And

_____

FEDERAL TAX ID # _____

1.0 Parties to the Contract

This Contract is entered into by and between the North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services, hereinafter referred to "Division" or "DMH/DD/SAS, (which is a Division under the North Carolina Department of Health and Human Services hereinafter referred to as the "Department" or "DHHS") and *LME-MCO NAME*, a political subdivision of the State of North Carolina, hereinafter referred to as the "LME-MCO".

2.0 Terms of Contract

The term of this contract shall be for a period, commencing Oct 1, 2011 and ending June 30, 2014.

3.0 Contract Documents

The following documents are incorporated herein by reference:

(1) Attachment I – Scope of Work

(2) Attachment I A – LME Housing Coordination Activities

(2) Attachment II – Performance Measures

(3) Attachment III – Financing

(4) Attachment IV – Informatics Center System Access Agreement

(5) Attachment V – IMT Purpose and Monitoring Responsibilities

In the event of a conflict in terms between the Contract Documents, the documents shall be accorded precedence in the following order: the Contract, Attachment I - Scope of Work, Attachment II – Performance Measures, Attachment III – Financing, Attachment IV – Informatics Center System Access Agreement, and Attachment V – IMT Purpose and Monitoring Responsibilities. Portions of this Contract relating to Medicaid financing and Medicaid services may require approval by the federal Centers for Medicare and Medicaid (CMS). Nothing in this Contract or the referenced Attachments shall be construed to create an entitlement to services purchased with State or State-allocated federal funds.

4.0 Assignment

No assignment of the LME-MCO's obligations or of the funding provided to the LME-MCO pursuant to this Contract shall be permitted. However, when assignments are made pursuant to changes in governance or counties participating in an LME-MCO, assignments may be made with prior written approval of DHHS, which approval shall not be unreasonably withheld. Upon such approved assignment, the assigned contract shall be deemed a novation.

5.0 Subcontracting

The LME-MCO may subcontract the functions contemplated under this Contract, subject to all applicable State and Federal laws and rules established by the Secretary of DHHS. The LME-MCO shall be responsible for the performance of any subcontractor. The LME-MCO shall inform the subcontractor of the sources of funding for the contract and of any special compliance or reporting requirements associated with each fund source (e.g. block grants). The LME-MCO shall establish procedures for the oversight, monitoring and evaluation of subcontractors to ensure accurate reporting and appropriate use of State and Federal funds. As a LME-MCO, the LME-MCO will maintain full accountability for all aspects of Waiver operations and for meeting all contract requirements specified by the Department. The Department shall not require LME-MCOs to subcontract any managed care functions or non-service activities to other entities. However, LME-MCOs may choose to subcontract managed care functions to other entities which will be limited to the following functions:

1. Information systems
2. Customer service (including call center) operations
3. Claims processing
4. Provider, enrollment, credentialing, and monitoring
5. Professional services
6. Treatment Plan development
7. Referral to services

6.0 Beneficiary

Except as herein specifically provided otherwise, this Contract shall inure to the benefit of and be binding upon the parties hereto and their respective successors. It is expressly understood and agreed that the enforcement of the terms and conditions of this Contract and all rights of action relating to such enforcement, shall be strictly reserved to the Department and the LME-MCO. Nothing contained in this document shall give or allow any claim or right of action whatsoever by any other third person. It is the express intention of the Department and LME-MCO that any person or entity, other than the Department or the LME-MCO receiving services or benefits under this Contract shall be deemed an incidental beneficiary only.

7.0 Entire Agreement

This Contract and any documents incorporated specifically by reference represent the entire agreement between the parties and supersede all prior oral or written statements or agreements, with the exception of the 1915 b/c waiver related contracts between the LME-MCO and the Division of Medical Assistance (DMA) and between the LME-MCO and the Division of State Operated Healthcare Facilities, Divisions of the Department.

8.0 Availability of Funds

The parties to this Contract agree and understand that the payment of the sums specified in this Contract is dependent and contingent upon the appropriation, allocation and availability of funds for this purpose to DHHS and the LME-MCO.

9.0 Responsibilities of the Department

The responsibilities of the Department are as follows:

(1) Approve the LME-MCOs submission of the RFA, per Session Law 2011 – 264, HB-916 follow fidelity of the 1915 b/c waiver, provide Inter-Departmental Monitoring and oversight with DMA, readiness reviews in the implementation and annual reviews in operational phase of the 1915 b/c waiver, as in Attachment V, and monitor the functions in accordance the terms of this Contract and the DMA contract;

(2) Verify the catchment area of an LME-MCO, area authority or a county program shall meet a minimum population of at least 300,000 as of July 1, 2012 and as July 1, 2013 shall be a minimum population of 500,000 per Session Law 2011 – 264, HB-916;

(3) Participate in the Intra-Departmental Monitoring Team (IMT) in Attachment V;

(4) Reimburse the LME-MCO for the costs of functions and activities as described in Attachment III; provided that DHHS shall reduce the LME-MCO's administrative funding by 10% annually if the LME-MCO does not comply with the catchment area requirements of G.S. 122C-115(a) and (a1); and provided further that nothing contained herein shall limit the Secretary's authority to suspend funding pursuant to G.S. §122C-124.1 and 147;

(5) Monitor the LME-MCO for compliance with the terms of this Contract and compliance with applicable State and federal laws, rules, regulations, policies, guidelines, and standards and publish individual and comparative reports regarding the LME-MCO's performance under this contract;

(6) Notify the LME-MCO of changes in covered services or conditions of providing covered administrative services;

(7) Collaborate with the LME-MCO on quality improvement activities, fraud and abuse issues, and other activities that impact the services provided to recipients;

(8) DHHS shall notify LME-MCOs of policy or procedure changes 90 days prior to effective date of change except, when changes in federal law regulations or

policy dictate adherence to a less than 90 day implementation timeline (or business conditions which necessitate a more expedient implementation).

(9) All other responsibilities contained in this Contract;

10.0 Responsibilities of the LME-MCO

The responsibilities of the LME-MCO are as follows:

(1) Serve as a Local Management Entity as defined by N.C.G.S. 122C-3(20b). for public mental health, developmental disabilities and substance abuse services in the LME-MCO's geographic territory;

(2) The LME-MCO will implement the RFA as accepted by DHHS, per Session Law 2011 – 264, HB-916 following fidelity to the 1915 b/c waiver, and perform the functions described in the RFA in accordance with its terms and the terms of this Contract and the DMA contract;

(3) Participate in IMT in Attachment V;

(4) Perform the functions outlined in Attachment I - Scope of Work;

(5) Manage service capacity and quality via enforcement of DHHS policy and applicable state and federal statutes including termination for cause of LME-MCO Provider contracts;

(6) Be wholly responsible for the work to be performed and for the supervision of its employees. The LME-MCO represents that it has, or shall secure at its own expense, all personnel required in performing the services under this Contract. Such employees shall not be employees of the Department;

(7) Utilize State and non-Medicaid federal funds allocated for services under this contract for Division of Mental Health/Developmental Disabilities/Substance Abuse Services (DMH/DD/SAS or DMH) approved mental health, developmental disabilities and substance abuse services for individuals in the catchment area or Cross Area Service Programs (CASPs) in accordance with DHHS Target Population categories and federal priorities;

(8) Submit to the Department all plans, reports or documents required by statute or duly adopted regulation, State or federal funding agreements, DHHS policy and this Contract;

(9) Monitor sub-grantees for compliance with the terms of subcontracts and ensure that sub-grantees comply with all reporting requirements of the LME-MCO;

(10) Allow the Department unrestricted access to all public meetings, activities, and documents pertaining to the fulfillment of functions or activities funded by this contract;

(11) Crosswalk consumers to the Client Name Data Service (CNDS) when the consumers are enrolled into the Consumer Data Warehouse (CDW), IPRS or NCTracks. (IPRS will be eventually replaced by NCTracks the new MMIS system so name and terminology subject to change);

(12) Accurate and timely submission of CDW, PCP, NC-TOPPS, IPRS target population eligibility, and other DMHDDSAS required data for each consumer as required by policy or other required Departmental data system;

(13) Set rates for services, determine financial incentives, sanctions and set financial limits on contracts funds;

(14) Provide enhanced Care Coordination services to consumers with mh/dd/sa needs deemed as high risk / high cost;

(15) Provide DMHDDSAS copies of all reports sent to DMA as a member of the IMT;

(16) Implement the approved LME-MCO crisis plan based on availability of crisis funding;

(17) Submit required cost reports (if applicable). Defend adverse actions taken by the LME-MCO against providers in all departmental and administrative hearings and in state and federal courts as applicable.

(18) Disclosure by LME-MCO of board membership and executive staff and LME-MCO contracted providers and fiscal agents: Information on ownership and control annually disclosing entities, fiscal agents, and managed care entities provide the following disclosures:

(i) The name and address of any person (individual or corporation) with an ownership or control interest in the disclosing entity, fiscal agent, or managed care entity. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address;

(ii) Date of birth and social security number (in the case of an individual)

(iii) Other tax identification number (in the case of a corporation) with an ownership or control interest in the disclosing entity (or fiscal agent or managed care entity) or in any subcontractor in which the disclosing entity (or fiscal agent or managed care entity) has a 5 percent or more interest.

(19) All other responsibilities contained in this Contract;

11.0 Accreditation for Management Functions

LME-MCO shall have evidence of a three year accreditation from a national accreditation body approved by the State and within one year from the initial date of this contract, as a waiver entity operating a PIHP, shall have achieved accreditation either from NCQA or URAC.

12.0 Notice of Certain Reporting and Audit Requirements

The LME-MCO shall use or expend the funds available under this contract only for the purposes for which they were appropriated by the General Assembly or received by the State. State funds include federal funds that flow through the State. The LME-MCO is

subject to the requirements of OMB Circular A-133 and the N.C. Single Audit Implementation Act of 1987, as amended in 1996.

The LME-MCO shall furnish to the State Auditor, upon his/her request, all books, records and other information that the State Auditor needs to fully account for the use and expenditure of state funds.

If the LME-MCO disburses or transfers state funds to other organizations other than for the purchase of goods or services, the LME-MCO shall require the recipient(s) to submit to the LME-MCO reports and statements required in G.S. § 143C 6-22 and 6-23 and the State Auditor's Audit Advisory # ADV-2005-001.

13.0 Record Retention

Both parties shall retain records at their own expense in accordance with the DHHS Record Retention Policy and applicable federal and state requirements per the Records Management and Documentation Manual APSM 45.2. At a minimum, parties shall maintain all grant records for a period of five years after the grant closes and a final expenditure report has been approved, provided there are no unresolved audit findings, pending litigation, claims, investigations or other official actions involving the records. If the final expenditure report is amended, or if any of the above actions take place during the ensuing timeframe, the five year retention period starts over.

LME-MCOs are also subject to the requirements of the Records Retention and Disposition Schedule for State and Area Facilities (APSM 10-3). In order to protect documents and public records that may be involved in DHHS litigation, the Department shall notify the LME-MCO when documents may be destroyed, disposed of, or otherwise purged through the biannual Records Retention and Disposition Memorandum from the DHHS Controller's Office.

The LME-MCO shall facilitate and monitor the compliance of its providers with all applicable requirements of record retention and disposition, which includes the implementation of the proper protections and safeguards for records [security, privacy, and storage] for the duration of the record retention period, including monitoring to assure that when a provider goes out of business, the provider has arranged for their records to be stored in an environment that ensures the continued preservation and safeguarding of records to protect their privacy, security, and confidentiality for the duration of the record retention period, and that the provider has submitted to the LME-MCO a copy of their record storage log and documentation that outlines where the records are stored, the designated custodian, and contact information.

LME-MCO contracted Providers are responsible and accountable for service record compliance as noted in their executed Division's contract of DMHDDSAS and DMA. The abandonment of records or any failure of the provider to safeguard the privacy, security, retention, and disposition of records is a violation of state and federal laws, and is subject to legal sanctions and penalties. The LME-MCO should take appropriate action upon notification of any situation where records have been abandoned, exposed, or susceptible to a privacy or security breach. After investigation by the LME-MCO and it is determined that a violation of health information privacy/security rights has occurred,

a formal complaint shall be filed with the Office of Civil Rights (OCR) as mandated by 45 CFR Part 160, Part 162 and Part 164 (HIPAA Privacy and Security Rule) and byTitle XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009 (ARRA), P.L. 111-5 the Health Information Technology for Economic and Clinical Health Act (HITECH Act). When an LME-MCO discovers that a provider has abandoned their records, the LME-MCO shall take possession of the abandoned records and notify the relevant national accrediting organization and all DHHS state agencies involved with associated provider, including but not limited to DMA, DMHDDSAS and DHSR, in addition to the federal reporting requirements noted above.

Final custody of the abandoned records lies with the LME-MCO if the provider had been contracted with State Funds or the provider was within the LME-MCO wavier network. Final custody of the abandoned records lies with DMA if the provider solely functioned within a direct-billing relationship for Medicaid MH/DD/SA services. DMA shall take possession from the LME-MCO and assume custody of abandoned records within 30 days of physical pick-up from the provider site. The final custodian of abandoned records assumes responsibility for the continued protection and accessibility of the record per HIPAA regulations. Such records shall be made available to consumers to facilitate continuity of care. In those cases where a record is subpoenaed and/or court-ordered, the LME-MCO may provide an uncertified copy of the records; however, the LME-MCO cannot certify that the records were maintained in the normal course of business, without defacement, tampering or alteration prior to receipt. Such an attestation can only be made by the provider whose responsibility and liability for the records continue after the dissolution of the business per sections 3, 5, 7, 9, 10, and 15 of the DHHS Provider Administrative Participation Agreement.

When an LME-MCO dissolves, the successor organization is obligated to assume responsibility for the records of the dissolved LME-MCO for the duration of the retention schedule for those records per the Records Retention and Disposition Schedule for State and Area Facilities (APSM 10-3). This includes client records, administrative records and other records covered by the retention schedule. The successor LME-MCO has the option of scanning the records and disposing of the paper copies or renting storage space and retaining the records in storage. These records can be disposed of when the retention period in the appropriate schedules has been met. Records which have met the retention schedule requirements shall be destroyed if these records are not subject to audit, investigation, or litigation.

14.0 Liabilities and Legal Obligations

Each party hereto agrees to be responsible for its own liabilities and that of its officers, employees, agents or representatives arising out of this Contract.

15.0 Compliance with Laws

The LME-MCO shall ensure that in all LME-MCO expenditures and reimbursements using state and federal funds, and in all LME-MCO subcontracting with entities that are

eligible to receive these funds, the LME-MCO staff and its subcontractors shall fully comply with all requirements and restrictions of the Substance Abuse and Treatment Block Grant (SAPTBG), Community Mental Health Services Block Grant (CMHSBG), Social Security Block Grant (SSBG), and their accompanying state Maintenance of Effort (MOE) requirements, The Projects to Assist in the Transition from Homelessness (PATH) formula grant, Strategic Prevention Framework-State Incentive Grant (SPF-SIG), Safe and Drug Free Schools and Communities Act (SDFSCA), and all other applicable federal grant program funds. The LME-MCO shall apprise all staff and contractors in writing of the requirements and restrictions of these funding sources and shall monitor compliance with these requirements and restrictions.

16.0 Amendment

All amendments shall be made in written form and executed by duly authorized representatives of the Department and the LME-MCO. This contract may not be amended orally or by performance. DHHS may unilaterally amend the terms of this Contract if it removes any one or more of the LME-MCO's functions pursuant to Chapter 122C of the North Carolina General Statutes. The parties agree that this contract shall be amended, as necessary, to maintain compliance with State or federal law, regulations or policy.

17.0 Choice of Law

The laws of the State of North Carolina shall govern and control this Contract. The parties agree that in litigation initiated by the LME-MCO, related to matters concerning this Contract, venue for legal proceedings shall be Wake County, North Carolina. The parties further agree that in any action initiated by DHHS against the LME-MCO under or arising from or involving the validity, construction, interpretation or enforcement of this contract, venue shall be appropriate in the County where the LME-MCO's primary administrative office is located.

18.0 Federal Certifications

The LME-MCO agrees to execute the following federal certifications:

(1) Certification Regarding Lobbying;

(2) Certification Regarding Debarment;

(3) Certification Regarding Drug-Free Workplace Requirements;

(4) Certification Regarding Environmental Tobacco Smoke.

19.0 Severability

In the event that a court of competent jurisdiction holds that a provision or requirement of this Contract violates any applicable law, each such provision or requirement shall continue to be enforced to the extent that it is not in violation of law or is not otherwise

unenforceable and all other provisions and requirements of this Contract shall remain in full force and effect.

20.0 Confidentiality

Any medical records, personnel information or other items exempt from the NC Public Records Act or otherwise protected by law from disclosure given to the LME-MCO under this contract shall be kept confidential and not divulged or made available to any individual or organization without the prior written approval of DHHS except as otherwise provided by law.

The provisions of 42 CFR, Part 2 – Confidentiality of Alcohol and Drug Abuse Patient Records and 45 CFR - HIPAA shall be fully applicable.

21.0 Termination

a. For Convenience:

This agreement may be terminated for convenience at any time by the mutual written agreement of the parties without additional liability to either party.

b. For Cause:

Pursuant to G.S. § 122C-125, this contract is terminable for cause by DHHS. Additionally, pursuant to Chapter 122C of the North Carolina General Statutes, DHHS may remove certain duties and responsibilities from the LME-MCO and may suspend funding to the LME-MCO and no provisions herein shall be construed to diminish, lessen, limit, share, or divide the authority of DHHS or the Secretary of DHHS to so act.

c. Should DMA for any reason terminate their contract with an LME-MCO operating a PIHP under the terms of this contract, DMHDDSAS will automatically terminate this Contract immediately for cause and the LME-MCO shall work with DMHDDSAS and DMA to provide Medicaid benefits to Enrollees and state funded individuals receiving services through other options available in the State.

22.0 Secretary's Authority Undiminished

Certain functions delegated to the LME-MCO pursuant to this Contract are the duty and responsibility of DHHS as the single state agency responsible for the administration of the North Carolina Medicaid program and as the grantee of federal block grant funds such as the Mental Health Block Grant, the Substance Abuse Prevention and Treatment Block Grant and the Social Services Block Grant. The parties understand and agree that nothing in this Contract shall be construed to diminish, lessen, limit, share, or divide the authority of the Secretary of DHHS to perform any of the duties assigned to the DHHS or its Secretary by the North Carolina General Statutes, the State Medicaid Plan, the Medicaid laws and regulations, the terms and conditions of the block grants and their applicable laws and regulations or other federal laws and regulations

regarding any federal funding which is used by DHHS to reimburse the LME-MCO for any of its contractual duties.

23.0 Originals

In witness whereof, the LME-MCO and Department have executed this Agreement in duplicate originals, one of which is retained by each of the parties.

24.0 Notifications Of Changes In the Contract

The persons named below shall be the persons to whom notices provided for in this Contract shall be given. Either party may change the person to whom notice shall be given. All notices shall be deemed received only when they are actually received.

For the Department of Health and Human Services:

Steve Jordan, Director
Division of Mental Health, Developmental Disabilities, and Substance Abuse Services
325 N. Salisbury St
3001 Mail Service Center
Raleigh, NC 27699-3001
Phone (919) 733-7011 Fax (919) 508-0951

For the LME-MCO:

_____ (Enter name and title)

_____ (Enter Agency's name)

_____ (Enter Street Address)

_____ (Enter P.O. Address)

_____ (Enter City, State, and Zip Code)

Phone (___) ____-_____ Fax (___) ____-_____ (Enter numbers)

25.0 Signature Warranty

Each individual signing below warrants that he or she is duly authorized by the party to sign this Contract and to bind the party to the terms and conditions of this Contract.

BY: _____ Witness: _____
Name

TITLE: _____

LME-MCO: _____

DATE: _____

North Carolina Department of Health and Human Services

BY: _____
Secretary or Designee

DATE: _____

ATTACHMENT I

PURPOSE, MISSION, VISION AND SCOPE OF WORK

PURPOSE:

The purpose of the 1915 b/c Waiver is to actualize DHHS and DMHDDSAS's Mission and Vision for North Carolina.

DHHS MISSION:

The mission of the Department of Health and Human Services is to provide efficient services that enhance the quality of life of North Carolina individuals and families so that they have opportunities for healthier and safer lives resulting ultimately in the achievement of economic and personal independence.

DMHDDSAS MISSION:

North Carolina shall endeavor to provide people with, or at risk of, mental illness, developmental disabilities and substance abuse problems and their families the necessary prevention, intervention, treatment, services and supports they need to live successfully in communities of their choice.

VISION:

Responsible change to achieve easy access, better quality and cost-effectiveness:

1. Public and social policy toward people with disabilities shall be respectful, fair and recognize the need to assist all that need help.

2. The state's service system for persons with mental illness, developmental disabilities and substance abuse problems shall have adequate, stable funding.

3. System elements shall be seamless: consumers, families, policymakers, advocates and qualified Providers shall unite in a common approach that emphasizes support, education/training, rehabilitation and recovery.

4. All human service agencies that serve people with mental health, developmental disabilities, and/or substance abuse problems shall work together to enable consumers to live successfully in their communities.

5. Within this vision, Consumers have:

    a. Meaningful input into the design and planning of the services system;

b. Information about services, how to access them and how to voice grievances;

c. Opportunities for employment in the system;

d. Easy, immediate access to appropriate services;

e. Educational, employment or vocational experiences that encourage individual growth, personal responsibility and enjoyment of life;

f. Safe and humane living conditions in communities of their choice;

g. Reduced involvement with the justice system;

h. Services that prevent and resolve crises;

i. Opportunities to participate in community life, to pursue relationship with others and to make choices that enhance their productivity, well being and quality of life;

j. Satisfaction with the quality and quantity of services; and

k. Access to an orderly, fair and timely system of arbitration and resolution.

6. Within this vision, Providers and Care Managers have:

a. The opportunity to participate in the development of a state system that clearly identifies target groups, core functions and essential service components;

b. Access to an orderly, fair, and timely system of arbitration and resolution;

c. Documentation and reimbursement systems that are clear, that accurately estimate costs associated with services and outcomes provided, and that contain only those elements necessary to substantiate specific outcomes required; and

d. Training in Services that are provided.

The values of Recovery, Self Determination, Person Centered Planning and Consumer and Family driven services are the basis for this waiver expansion, and are in the North Carolina State Plan.

7. GOALS OF THE EXPANSION:

a To provide a funding strategy that includes single management of all resources through a public local system manager in order to provide for coordination and blending of funding resources; collaboration with out- of-

system resources; appropriate and accountable distribution of resources; and allocation of the most resources to the people with the greatest disabilities;

b To transition the local system toward treatment with effective practices that result in real life recovery outcomes for people with disabilities;

c To promote community acceptance and inclusion of people with disabilities, to provide outreach to people in need of services, to promote and ensure accommodation of cultural values in services and supports, and to serve people in their local communities whenever possible;

d To provide for easy access to the system of care;

e To ensure quality management that focuses on health and safety, protection of rights, achievement of outcomes, accountability, and that strives to both monitor and continually improve the system of care;

f To empower consumers and families to set their own priorities, take reasonable risks, participate in system management, and to shape the system through their choices of services and Providers;

g To empower the LME-MCO to build local partnerships with the people who depend on the system for services and supports, with community stakeholders and with the providers of service; and

h To demonstrate an interactive, mutually supportive, and collaborative partnership between the State Agencies and the LME-MCO in the implementation of public policy at the local level and realization of the state's goals of system reform delineated in the Blueprint for Change.

The LME-MCO-MCO, as a public local system manager and implementer of the State's public policy, has developed the infrastructure and functional capacity to direct, coordinate, manage, and ensure accountability in this transformation of the local system and to attain the goals established in this Contract.

The LME-MCO shall perform all Local Management Entity (LME-MCO) functions in accordance with DHHS requirements. This contract creates no rights on behalf of the providers. In the event that funding for LME-MCO functions is reduced, the scope of work shall be reviewed within thirty (30) days of such funding reduction. The functions include:

(1) General Administration and Governance;
(2) Business Management and Accounting;
(3) Information Management Analysis and Reporting;
(4) Claims Processing;
(5) Provider Relations;
(6) Access, Screening, Triage and Referral;

(7) Service Management
(8) Consumer Affairs and Customer Service;
(9) Quality Management

1.0 General Administration and Governance

1.1. Area Board and Consumer and Family Advisory Committee (CFAC) Relationship

At the request of either the CFAC or the governing board of the area authority or county program, the CFAC and the governing board shall execute an agreement that identifies the roles and responsibilities of each party, channels of communication between the parties, and a process for resolving disputes between the parties.

1.2. Area Board Meetings

The LME-MCO shall ensure that the Board meets the composition requirements of G.S. § 122C-118.1 and G. S. § 122C-119 and in accordance with G.S. § 122C-119(a) and shall meet at least six (6) times per year. The LME-MCO shall provide an annual training, information and/or sufficient support to ensure that the Board actively reviews regular reports on finances, local performance, unmet local service needs, provider capacity and compliance with service requirements, and trends in service utilization, consumer health and safety, customer service, and complaints and appeals. Unless delineated elsewhere, each LME-MCO shall define training needs.

1.3. Consumer and Family Advisory Committee (CFAC) Meetings

The LME-MCO shall provide sufficient financial and administrative support to ensure that the CFAC shall meet the composition requirements of G.S. § 122C-170 and shall meet at least six (6) times per year. The LME-MCO shall provide sufficient training on the LME-MCO business plan, budget, and other topics to support the CFAC's review of reports on finances, local performance, and customer service on a regular basis.

1.4. Area Director Evaluation

The Area Board shall ensure that its annual evaluation of the Area Director includes an evaluation of the criteria established by the NC Secretary of DHHS in Communication Bulletin # 20, dated June 1, 2004 which referenced 122C-121(b).

1.5. Capacity and Competency

The LME-MCO shall have an administrative and organizational structure adequate to perform the functions required under this contract. The LME-MCO shall employ qualified personnel sufficient to carry out the requirements of this contract. This includes ensuring sufficient numbers of staff meeting the CMS definition of Skilled Professional Medical Personnel (SPMP) and clinical staff competent in all three

disability areas. The LME-MCO shall ensure that all staff persons have the training, education, experience, licensing or certification appropriate to their position and responsibilities.

1.6. Conflict of Interest

The term "conflict of interest" refers to situations in which financial or other personal considerations may adversely affect, or have the appearance of adversely affecting, an individual's professional judgment in performing any activity or duty in connection with this contract. No official or employee of the LME shall acquire any personal interest, direct or indirect, in any provider network. The LME Board of Directors, advisory committees, employees, volunteers, agents and contractors shall refrain from participation in clinical or administrative activities or decisions in which there is or may be a conflict of interest.

The LME-MCO-MCO shall not serve as legal guardian for any recipient of either enrollee of Medicaid or State Funded mental health, developmental disabilities or substance abuse services.

2.0 Business Management and Accounting

2.1. Management of State Service Funds

The LME-MCO shall establish policy and procedures that ensure that funds are available to reimburse providers for duly authorized services provided and billed. This includes estimating the percentage of authorized services that shall be delivered so that only those funds that shall be spent are encumbered. The LME-MCO shall use the approved DHHS contracts, NCGS 122C-142, for purchasing services from providers and shall comply with the statewide claims processing requirements.

2.2. Financial Records

In addition to meeting all applicable state and federal statutory and regulatory requirements, the LME-MCO shall comply with applicable Generally Accepted Accounting Principles and GS Chapter 159, as appropriate. The LME-MCO shall maintain up-to-date and accurate accounting records for accounts payable and receivable. The LME-MCO shall submit to its Board a monthly finance report that includes an income statement and except for single counties a balance sheet. The LME-MCO shall submit other financial information to its Board, the boards of county commissioners, county managers/finance officers, CFAC and DHHS as set forth in various provisions of G.S. Chapter 122C.

2.3. Contracting for Service Delivery

The LME-MCO, per Session Law 2011 – 264, HB-916 following fidelity to the 1915 b/c waiver, shall use the contract templates approved by the Department of Health and Human Services G.S. 122C-142(a) upon approval from the Secretary when contracting for state and non-Medicaid federal funded services. All provider contracts must specify

that the provider shall conform to the provisions of this Contract and comply with all applicable federal and state laws, regulations, and policies. All provider contracts shall be in writing. The LME-MCO shall retain one fully executed original of each provider contract. The LME-MCO shall make provider contracts available for the Department's inspection and copying within two working days after it receives the Department's written request. The LME-MCO shall not contract with any provider that has been debarred, suspended terminated or otherwise lawfully prohibited from participation in any federal or state government procurement activity. The LME-MCO shall only contract with not-for-profit organizations when using federal block grant funds. Pursuant to Attachment III, 3.0, state and non-Medicaid funds may only be used to purchase services that conform to state-approved service definitions.

2.3.1 Mobile Crisis Provider Contracts: Mobile Crisis and NC START Affiliation Agreements

The purpose of NC START is to provide community based prevention and intervention services to individuals, ages 18 years and older with a diagnosis of intellectual and/or developmental disability (I/DD) and behavioral health needs. The goal of NC START involvement is to support providers to help individuals remain in their home or community placement with crisis response, training, consultation, and respite. To do so, NC START establishes collaborative linkages with system partners.

Although the model provides specialized services through a team of individuals, such as crisis support, psychiatry and emergency respite, the main emphasis of the model is on service linkages rather than a segregated service system for individuals with IDD.

To ensure that effective linkages are established and maintained between NC START and Mobile Crisis, the LME-MCO will include within all Mobile Crisis provider contracts a requirement that a formal, written affiliation agreement be established and maintained with the NC START team in their regions. The agreements will be developed collaboratively between the Mobile Crisis Teams and regional NC START team and will outline the roles and responsibilities of both parties.

3.0 Information Management

3.1. Information Technology Infrastructure

The LME-MCO must have the ability to send files in standard Electronic Data Interchange (EDI) format. All electronic Protected Health Information (PHI) must be encrypted. The LME-MCO's IT infrastructure shall be fully compliant with the Administrative Simplification Provisions, Sections 261 through 264, of the federal Health Insurance Portability and Accountability Act of 1996, (HIPPA), Public Law 104-191; the HIPAA Privacy and Security regulations in 45 CFR Parts 160, 162, and 164; and the regulations governing the Confidentiality of Alcohol and Drug Abuse Patient Records in 42 CFR Part 2. The LME-MCO must have an internet connection and browser capabilities as well as file sharing capabilities with File Transfer Protocol (FTP) Software.

3.2. Federal Health Information Technology Interoperability Standards

In the implementation of electronic health record technology and throughout all of their information technology applications used in the support of an electronic health record, the LME-MCOs shall monitor and adhere to the Federal health information technology interoperability standards that shall be specified as a result of the American Recovery and Reinvestment Act of 2009 (http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h1enr.pdf) specifically, but not exclusively Title XIII - Health Information Technology (short title "Health Information Technology for Economic and Clinical Health Act" or the "HITECH Act")."

3.3. Consumer Information

The LME-MCO shall manage the provider network and community capacity of services and ensure that providers submit to the LME-MCO in timely manner information on individuals requesting and/or receiving services through federal, state and county funds. The LME-MCO shall maintain accurate and up-to-date consumer information and eligibility records in a manner which protects the privacy rights of consumers. The LME-MCO shall request and record consumer social security numbers only when it is imperative for the performance of that agency's duties and responsibilities as prescribed by law (G.S. § 132-1.10) The LME-MCO shall submit timely consumer screening, admissions, updates, discharges, and eligibility information to DHHS, as specified in DHHS policy, including additions, deletions, and changes in consumer status. The LME-MCO shall ensure that providers submit required information within the time frames set by the LME-MCO and according to DHHS policy.

3.4. ITS User Information

DHHS requires a monthly validation of all users of the state IT system (RACF-ID). To this end LME-MCO's shall submit a monthly validation report to DHHS in a form and manner to be specified by DMH. Failure to comply with this requirement may result in a revocation of access to the state IT system.

3.5. Analysis of Data (LME-MCO Data and Community Care of North Carolina (CCNC))

The LME-MCO shall analyze consumer access, and process service authorization and claims payment data to inform management decision-making in areas including: identification of high cost/high need consumers; provider billing patterns and trends; utilization of various services in the service array; identification of gaps in the service array; consumer movement among providers, consumer access, initiation, engagement, retention, continuity of care and personal consumer outcomes.

The LME-MCO shall also partner with CCNC in sharing of information to inform management decision making in areas of consumer access, initiation, engagement, retention, continuity of care, and other areas approved in Attachment IV CCNC Informatics Agreement.

3.6 Encounter Data:

The MCO shall have the ability to send and receive the HIPAA transactions. Transactions that will be used beginning on program inception include the following:

a. 820 – Premium Payment (DMA only)
b. 834 – Member Enrollment and Eligibility Maintenance
c. 835 – Remittance Advice
d. 837P – Professional claims
e. 837I – Institutional claims
f. 997 - Batch acknowledgement for 4010 version
g. 999 - Batch acknowledgement for 5010 version

All encounter data submitted by the LME-MCO to DMA, the MMIS or a contractor acting on DMA's behalf shall include the NPI of the Network Provider.

When the MMIS is revised to accept and process encounter data, the LME-MCO shall submit to DMA an electronic record of every encounter between a network Provider and an Enrollee within fifteen (15) days of the close of the month in which the specific encounter occurred, was paid for, or was processed, whichever is later, but no later than 180 days from the encounter date. DMA shall conduct validation studies of encounter data, testing for timeliness, accuracy and completeness. The LME-MCO shall report all encounters that occur up to the date of the termination of this Contract. The LME-MCO is subject to sanctions for late or incomplete submissions in accordance with the terms of SOW Section 13. If the Contract terminates while payments are being withheld by DMA due to inaccurate or late reporting of encounter data, DMA shall continue the withhold until the LME-MCO reports all encounter data according to Contract Attachment W, Financial Reporting Requirements.

3.7 Website

The LME-MCO shall maintain a web site on the Internet that includes current and accurate information on how consumers and families may access services in the catchment area. The home page shall prominently identify the toll free telephone number(s) the public may call for access to services and to address other customer service needs.

4.0 Claims Processing

4.1 Provider Billings Made Through the LME-MCO

The LME-MCO shall honor provider billing for State funds that are filed in accordance with the LME-MCO's contract with the provider. If the provider bills within Ninety (90)

days of providing a service, the LME-MCO will pay claims in accordance with the Division prompt pay requirements set forth as follows: within eighteen (18) calendar days after the LME-MCO receives a claim from a provider, the LME-MCO shall either: (a) approve payment of the claim, (b) deny the claim, or (c) determine that additional information is required for making an approval or denial. If the LME-MCO approves the payment, the claim shall be paid within 30 calendar days after making approval.

The LME-MCO shall disallow claims in the event and to the extent the claim is incomplete, does not conform to the applicable service authorization, or is otherwise incorrect. Any disallowed claims billed shall be returned to the provider with an explanation for the disallowance. The LME-MCO shall allow providers to re-submit a disallowed billing for re-consideration, so long as the re-submission occurs within the general claims filing timeframes outlined above. The LME-MCO shall cooperate with its contract providers in the prompt reconciliation of disallowed billings.

All payments for services to providers shall be provisional and subject to review and audit for their conformity with Division requirements and those of any applicable subcontract.

4.2 First and Third Party Payments

The LME-MCO shall work with its providers to pursue all applicable first and third party payments for services in order to minimize the usage of public resources. In the event that a consumer has third party coverage or is determined to be able to pay any portion of the cost of services in accordance with G.S. § 122C-146, the LME-MCO shall coordinate benefits so that costs for services otherwise payable by DHHS are avoided or recovered from a liable first or third party payer. The LME-MCO's claims system shall include appropriate edits for coordination of benefits and third party liability.

The LME-MCO or its provider contractors may retain any first or third party revenue obtained if both of the following conditions exist:

(1) Total collections received do not exceed the total cost of services for all persons served, and
(2) State and federal law does not require the state to recover first and third party payments from the LME-MCO.

The LME-MCO shall obtain, or require its State contracted providers to obtain, all relevant payer information from each consumer to be served, his or her guardian and/or family. This information shall be collected at the consumer's first encounter with the LME-MCO or its contract provider, but no later than the submission of the first claim to services, except in the case of crisis and emergency services in which circumstances such information shall be collected at the first clinically appropriate occasion. The LME-MCO shall provide available information to each provider involved with the consumer and require the provider to collect the remaining information, if applicable. The LME-MCO shall require providers to report first and third party collections on individual claims. The LME-MCO shall in turn report first and third party collection on individual claims sent to the MMIS+ or NCTracks system.

5.0 Provider Relations and Support

5.1. Assessment of Adequacy of the Provider Community

Under the terms of this Contract, the DHHS delegates the authority to develop and manage a qualified provider community in accordance with community needs including enrollment, disenrollment, and certification of providers including assessment of qualifications and competencies in accordance with applicable state and federal rules, standards and the provider qualifications established by the LME-MCO and deemed necessary for the effective provision of quality services. Any LME-MCO that receives state or federal funding for a Cross Area Service Program (CASP) (as described in Attachment I, 7.3.7), to provide comprehensive regional or statewide services across multiple LME-MCOs, shall collaborate with the DMH/DD/SAS to designate a provider to receive such designated CASP funds to serve the needs of an identified population.

The LME-MCO shall conduct a community need and provider capacity assessment during the first quarter of this contract, using a standardized process and reporting format defined by the Secretary. The assessment shall take into consideration the population in the catchment area, identified gaps in the service array, including gaps for underserved populations, perceived barriers to service access, and the number and variety of age-disability providers for each service. The assessment shall include input from consumers, families, community stakeholders, and CFAC. In evaluating the adequacy of the provider community the LME-MCO shall consider issues such as the cultural and linguistic competency of existing providers and provisions of evidence based practices and treatments and the availability of community services to address housing and employment issues. The assessment shall also measure the availability of providers willing to participate in community emergency response efforts, such as providing services in temporary housing shelters in the event of a natural disaster which triggers an evacuation. The LME-MCO shall report the results of the assessment using a standardized format to the DHHS, CFAC and the Area Board, and provide updates as needed to the Board and CFAC. The LME-MCO shall demonstrate that it is engaged in development efforts to address service gaps identified in the assessment.

In addition, the LME-MCO shall assess community need and provider capacity for children's services within the LME-MCO catchment area. The LME-MCO shall contract with a sufficient number of state-funded and non-Medicaid federally-funded service providers to ensure that children receive services in settings which are more likely to maintain or develop positive family and community connections.

If the gap analysis identifies an absence of provider(s) for any MH/DD/SA service, the LME-MCO's shall submit a plan to DHHS for developing a local provider community that offers choice for each service in their LME-MCO catchment areas in the next state fiscal year.

5.2. Choice of Providers and Treatment

The LME-MCO shall ensure that, except for services with very limited usage or services for which there is not sufficient demand or funding to support more than one provider, consumers have a choice of service providers consistent with CMS waiver requirements and DMHDDSAS. However, the LME-MCO is vested with the responsibility, under this contract, to decide the number of providers and which providers shall become members of the LME-MCO's provider network after the initial closure of the provider network.

For State-funded services, consumers shall have a choice of at least two providers for every service, except for those services with very limited usage and where alternative providers cannot be recruited.

The LME-MCO shall endeavor to ensure consumers have a choice of evidence based practices and treatments. The LME-MCO shall give consumers information on available providers to support selection of a provider.

5.3. Provider Manual

The LME-MCO shall develop, maintain, and distribute a Provider manual that informs providers and potential providers of the LME-MCO and DMHDDSAS processes, procedures, deadlines, and other information about the LME-MCO. This distribution may occur by making the manual available electronically on its website. DMHDDSAS and DMA shall have the right to review and approve the Provider manual prior to its release. The manual shall contain, or refer providers to, consumer rights information, service definitions, documentation and billing requirements, medical records requirements, consumer confidentiality and HIPAA privacy protections, etc. The manual shall be updated at least annually. At a minimum, the Provider manual shall cover the areas listed below.

a. Purpose and mission;

b. Treatment Philosophy and Community Standards of Practice;

c. Behavioral health Provider Network requirements, including: nondiscrimination, on-call coverage, credentialing, re-credentialing, access requirements, no-reject requirements, notification of changes in address, licensure requirements, insurance requirements, and required availability;

d. Appointment access standards;

e. Authorization, utilization review, and care management requirements;

f. Care Coordination and discharge planning requirements;

g. Documentation requirements, as specified in APSM 45-2 or as required by the Physician's Services Manual;

h. Provider appeals process;

i. Complaint investigation and resolution procedures;

j. Performance improvement procedures, including at a minimum: Recipient satisfaction surveys; Provider satisfaction surveys; clinical studies; incident reporting; and outcomes requirements;

k. Compensation and claims processing requirements, including required electronic formats, mandated timelines, and coordination of benefits requirements; and

l. Patient rights and responsibilities.

The LME-MCO shall provide to Providers any and all training and technical assistance it deems necessary regarding administrative and clinical procedures and requirements, as well as clinical practices.

5.4. Enrollment of Providers

5.4.1. Credentialing:

The LME-MCO shall have written policies and procedures for provider credentialing, re-credentialing, initial qualifications, accreditation, and re-accreditation, in accordance with community standards in care and service provision, and the rules and standards of the Division. The LME-MCO will implement its policies and procedures for credentialing, recredentialing, provider qualification, accreditation and re-accreditation with providers with which it has signed contracts or participation agreements. Such providers fall under its scope of authority and action under the terms of this Contract and for all services provided with funding from DMH/DD/SAS. The LME-MCO shall maintain credentialing, qualification and accreditation records that demonstrate compliance with its policies and procedures. These records shall be made available to DMH/DD/SAS during business hours. The credentialing, recredentialing, accreditation, and reaccreditation criteria must be consistent with State and Federal regulations governing the professional areas for those providers. The LME-MCO shall monitor licensed, certified, registered or accredited providers for continued compliance with these criteria.

5.4.2 Enrollment:

The LME-MCO may deny enrollment of providers in its network based on determination of qualification or need for the type of service offered by the provider. If the LME-MCO declines to enroll individual providers or provider agencies within its Network, it must give the affected providers written notice of the reason for its decision. If the LME-MCO has determined that it has sufficient numbers of providers to meet the needs of its consumers, it is not obligated to conduct qualification, credentialing or accreditation review of providers requesting to join its network. The LME-MCO shall have written policies and procedures for the determination of need, selection and retention of Network Providers.

5.4.3 Provider Selections:

The LME-MCO is not required to contract with providers beyond the number necessary to meet the needs of its enrollees.

The LME-MCO may use different reimbursement amounts for different specialties or for different practitioners in the same specialty; and will establish measures that are designed to maintain quality of services, control cost consistent with its responsibilities to enrollees.

The LME-MCO will monitor provider performance and will utilize information obtained from the standardized monitoring tools and other monitoring activities, Utilization Management Program on over – and – under utilization, service effectiveness, submission of required data and reports, Quality Management Program that establishes quality of care outcome measures and thresholds, Accreditation Outcomes, consumer incidents Grievance, Appeal, Complaint logs, Enrollee satisfaction surveys, and other quality improvement information in decisions to re-accredit, re-credential and re-enroll providers for its network. The LME-MCO shall provide training and technical assistance it deems necessary and practical to providers regarding administrative and clinical procedures, and requirements, as well as clinical practices.

The LME-MCO shall develop, maintain, and distribute a provider manual as identified in Section 5.3 that provides information and education to providers about providing services in the LME-MCO Network. This distribution may occur by making the manual available electronically and on its website and giving providers notification of revisions.

The LME-MCO shall publish a manual for consumers that identify enrolled providers, services provided, and populations served.

5.5. Provider Monitoring

The LME-MCO shall monitor non-Medicaid funded, Medicaid and Health Choice providers in accordance with DHHS policy and applicable statutes. DHHS will delegate program integrity and monitoring activities to the LME-MCO. Monitoring shall include, but is not limited to, determining providers' progress in achieving national accreditation, compliance with federal and state confidentiality laws, compliance all requirements and restrictions of the SAPTBG, CMHSBG, SSBG, and their accompanying state MOE requirements, PATH formula grant, SPF-SIG, SDFSCA, and all other applicable federal grant program funds requirements and restrictions on the expenditure of funds, first responder capacity and quality, compliance with data submission requirements, consumer rights protection, incident reporting and rights protection requirements, meeting defined quality criteria, compliance with regulatory and licensure board requirements for qualifications of staff, adherence to evidence based practices in the delivery of services and compliance with DHHS documentation requirements.

The LME-MCO shall assure a stable and high quality provider system in the LME-MCO's catchment area. The LME-MCO shall monitor providers to ensure that they remain in compliance with criteria following their credentialing and enrollment standards. The LME-MCO shall utilize a Monitoring protocol, based upon Session Law 2011 – 264, HB-916 following fidelity to the 1915 b/c waiver, to determine a confidence level and consequent monitoring frequency for providers in their catchment area or other requirements as outlined and adopted by the Affordable Care Act (ACA) rules April 1, 2011 (42-CFR-455 and 456).

In addition to ongoing monitoring responsibilities for the providers in the LME-MCO catchment area, it is a function of the LME-MCO to ensure a stable and high quality provider system, and to assure the Division that providers in the LME-MCO catchment area are in substantial compliance with the requirements of the service(s) they are enrolled to deliver.

LME-MCOs shall cooperate with the DMH/DD/SAS to ensure Block-Grant funded providers' participation in the DMH/DD/SAS's Independent Peer Reviews in compliance with federal Block Grant regulations.

5.6. Technical Assistance to Providers

In order to foster a stable and high quality provider system, the LME-MCO may offer technical assistance to providers to assist them in navigating the MH/DD/SA system. The LME-MCO shall provide guidance regarding the requirements of the State MH/DD/SA, NC Medicaid system and LME-MCO protocols. The LME-MCO may offer any technical assistance that serves the purpose of assuring an adequate supply of providers for consumers in the LME-MCO's catchment area. The LME-MCO shall not be required to provide any technical assistance that would be considered a normal operational procedure of a service provider. The LME-MCO shall not be required to provide technical assistance to a provider who has not assimilated previous technical assistance into its provider infrastructure.

5.7. Provider Complaints

Pursuant to G.S. 122C-151.3, the LME-MCO shall establish written procedures for local level informal dispute resolution with providers. Provider disputes may be appealed to the LME-MCO Appeals Panel. The LME-MCO shall respond to complaints from providers in a timely manner.

6.0 Access, Screening, Triage and Referral

6.1. Telephonic Access / Customer Services Call Center

The LME-MCO shall provide toll free access lines to its entire catchment area. The toll free lines shall be widely disseminated throughout the catchment area through written and broadcast public service announcements, and by including the number prominently in all LME-MCO publications and on the LME-MCO website. The LME-MCO shall publicize priority preference for substance abuse admission and treatment for injecting drug users and substance using pregnant women."

The LME-MCO operating a Telephonic Access / Customer Services call center designed for a manage care organization of an LME. The Telephonic Access / Customer Services call center is designed to receive a high volume of calls ranging from enrollee information, provider information, community resource information, enrollee / individual grievance and complaints, provider complaints, to screening, triage,

and referral / crisis type calls. The Telephonic Access / Customer Services staff answering the phone in the customer services call center need to have a high level of sophistication in processing a wide range of calls with appropriate disposition within the LME-MCO and demonstrating the ability to submit the information on the LME-MCO's electronic reporting system at the time of the call. The function of screening, triage, and referral is required to be completed by a Qualified Professional and /or by a licensed professional. A licensed clinician will be on-site for consultation. If the call is determined to be of clinical in nature such as an individual needing an assessment or screening either in routine, urgent or emergent type call, the customer call center staff will do a warm line transfer to an available qualified professional either within the Telephonic Access/Customer Services call center, the Care Coordination department or the Care Management/Utilization Management department within the LME-MCO for screening, triage, and referral. The Customer Services staff must have a high level of sophistication in being able to process a broad range of calls. This position would require significant level of job orientation, a high level of training, live call monitoring, supervision and back up support, and supervisor sign off prior to being allowed to work independently in the customer call center.

The LME-MCO shall host a direct, toll free TTY access line. The LME-MCO shall utilize a Relay Service (Telephone or Video) when telephonic assistance from a Relay Service is requested by a consumer.

Foreign language interpretation shall be available at no cost to the caller in compliance with the Limited English Proficiency requirements of Title VI.

When calling the access line, the consumer shall not be required to navigate an automated calling menu.

The LME-MCO qualified professional and/or emergency response staff shall have electronic access to the crisis plans if submitted by providers, of consumers currently actively receiving services in their home LME-MCO's catchment area in order to expedite crisis services. The LME-MCO staff shall have the ability to schedule appointments within 24 hours of initial contact.

6.2. Screening

The LME-MCO shall ensure that consumers who have not received any service in the past 60 days and who present in person or who contact the toll free access line are screened by a qualified professional. The LME-MCO shall ensure that all of the elements specified in the State's uniform screening tool are collected for persons screened by the LME-MCO or its providers and those elements are captured in the LME-MCO's electronic reporting system and reported to CDW as required by the CDW Reporting Requirements and Data Dictionary. Screening shall include a preliminary determination of target population eligibility. Screening shall also include an assessment of the urgency of the consumer's needs. The LME-MCO shall ensure that entities contracted to conduct screening, triage and referral activities for the LME-MCO use and submit the information on the LME-MCO's electronic reporting system in a

timely manner. Persons with substance use or abuse concerns shall be identified and triaged as persons with either Emergent or Urgent need.

6.3. Triage and Referral

The LME-MCO qualified professional or licensed clinician shall refer consumers to the providers of their choice, subject to the following access standards:

(1) Consumers experiencing an emergency (immediate need) are able to access emergency services through the LME-MCO and receive face to face services within two hours of the request for service.

(2) If the consumer need does not constitute an emergent (immediate need) situation, but is nonetheless urgent (an urgent need is a consumer who presents moderate risk or incapacitation in one or more areas of safety or physical, cognitive, or behavioral functioning related to mh/dd/sa problems) rather than a routine need, the LME-MCO shall refer consumers to a provider capable of delivering face-to-face services within 48 hours of the request for services.

(3) The LME-MCO shall refer consumers with a routine need (a routine consumer presents with mild risk or incapacitation in one or more areas of safety or physical, cognitive, or behavioral functioning related to MH/DD/SA problems) for service to a provider capable of delivering face-to-face services within 14 calendar days of the request for services.

The LME-MCOs shall report quarterly to the DHHS a summary of consumers screened, triaged and referred, using the approved DHHS form and definitions.

6.4. Access to State Operated Facilities

A single entry mechanism shall be in place for admission to and discharge from State operated institutions.

The LME-MCO Director shall serve as the designee of the Director of the DMH/DD/SAS of Mental Health, Developmental Disabilities and Substance Abuse Services in approving admission to State psychiatric hospitals in accordance with G.S. § 122C-261(f)(4). In so doing, the LME-MCO Director shall ensure that every effort has been made to identify an appropriate alternative treatment location prior to approving the admission to a State psychiatric hospital.

7.0 Service Management

7.1. Medical Director

The LME-MCO shall have a Medical Director who is employed or contracted in this position and responsible for the coordination of clinical policy and clinical monitoring between DMH/DD/SAS, DMA Clinical Policy, CABHA's and other local providers. In coordination with DMH/DD/SAS and local providers, the LME-MCO Medical Director participates in the development of practice guidelines and evidence-based care including, the integration of medical and psychiatric care in conjunction with the

DMH/DD/SAS Medical Director, DMA Clinical Policy, CABHA Medical Directors, CCNC Psychiatrist, and other interested parties. The LME-MCO Medical Director oversees the dissemination of clinical policy, monitoring of fidelity to evidenced-based models of care, and coordination of ongoing education of providers in relation to best practice. The LME-MCO Medical Director oversees the quality management and ongoing monitoring of patient outcomes within the LME-MCO catchment area. The LME-MCO Medical Director collaborates with the DMH/DD/SAS Medical Director, CABHA Medical Directors, CCNC Psychiatrist, and the Medical Directors of state hospitals, other state facilities, non-state hospitals, and other organizations in network development, network operations, and coordination of care among providers (both targeted and non-targeted populations). This includes promoting coordination of services and policies with such organizations and other local stakeholders.

7.2. Service Management

7.2.1. Utilization Management

The LME-MCO shall evaluate the medical necessity, clinical appropriateness, efficiency, and effectiveness of health care services for consumers receiving or requesting services against established guidelines and criteria.

The LME-MCO shall have sufficient numbers of experienced and qualified utilization, care management, and care coordination staff to meet the terms of this Contract. Utilization managers and care managers for individuals with mental health/substance abuse needs shall be at minimum Master's level Behavioral Health professionals licensed by the State of North Carolina with a minimum of two years post-Master's experience in a clinical setting with the population served. Utilization managers, care managers, care coordination staff for developmental disabilities services shall be completed by a Qualified Professional in the area of Developmental Disabilities as specified in 42 CFR 483.430 (a) and N.C. Gen. Stat. §122C-3;

7.2.2. Benefit Design

The LME-MCO shall adopt and publish during the term of this contract the benefit plan for target population consumers that define the services that individuals in each target population may expect to receive. The benefit plan shall be flexible to maximize the services that consumers may receive while ensuring the LME-MCO delivers services within available funding. Nothing in this contract shall be construed or interpreted as creating an entitlement to state funded services.

7.2.3. Crisis Services

The LME-MCO shall arrange for a 24/7/365 crisis response service as mandated by G.S. § 122C-117(a) (14). The LME-MCO shall have a full array of crisis services within its provider network which supports consumers and the community. The LME-MCO shall build a community collaborative of crisis/emergency stakeholders that engage in and support crisis prevention, crisis stabilization, and engagement of individuals into

services after a crisis event promoting hope, self-direction, recovery, and wellness using community services and natural supports.

7.2.4. Person Centered Plan Review

The LME-MCO shall review and approve Person Centered Plans (PCP) for consumers receiving services that require PCPs. This review shall assess the:

(1) Providers' use and implementation of the Records Management and Documentation Manual
(2) Compliance with DHHS policies, procedures, and guidelines;
(3) Inclusion of basic medical care such as: linkage to a medical home.

The LME-MCO shall ensure that information regarding the quality and completeness of the plans produced by individual providers is communicated to LME-MCO staff responsible for oversight and credentialing of providers.

7.2.5. Service Authorization

The LME-MCO shall authorize state-funded services based upon a properly completed PCP/Service Plan (as required) and in accordance with the LME-MCO's benefit plan for the consumer's target population. The LME-MCO shall respond to properly completed and submitted routine State service authorization requests within 14 calendar days; and urgent requests within 24 hours. Service authorizations shall be considered as a commitment to pay (within agreed upon contract limits) when the service is appropriately rendered and documented.

7.2.6. Consumer Notification of LME-MCO Service Authorization Decisions

The LME-MCO shall notify consumers when services are denied, reduced or terminated by the LME-MCO. This notification shall be in accordance with state and federal law and DHHS Medicaid Recipient Due Process Rights and Prior Approval Policies and Procedures and shall advise the consumer of how to exercise their appeal rights regarding the decision.

7.2.7. Post-Payment Clinical and Administrative Reviews

The LME-MCO shall conduct post-payment reviews of funded services to ensure that services delivered are clinically appropriate and provided in accordance with the NC Administrative Code; the DMH/DD/SAS Records Management and Documentation Manual; the Person-Centered Planning Instruction Manual; DMA Clinical Coverage Policies including service definitions; DMHDDSAS policies and communications; the North Carolina General Statutes and the Federal Code of Regulations. The LME-MCO has the authority and responsibility to make clinical and administrative determinations relating to quality and quantity of services rendered by Providers enrolled by the LME-MCO.

The LME-MCO shall work with the DHHS to identify high risk or high concern areas in which to conduct Post Payment Reviews (PPR). As the DHHS representative, the LME-MCO shall develop, maintain and implement an ongoing plan that addresses the scope

and conduct of post-payment reviews of Medicaid and non-Medicaid funded services. These post-payment reviews shall include SAPTBG and CMHSBG funded services and state funded MOE services in accordance with federal regulations and requirements, and as described in federal review and audit findings. Following completion of the Medicaid PPR's, the LME-MCO shall report its specific findings to the DMA Program Integrity Unit and DHHS using standard referral documents and protocols as follows:

(1) Referrals to DMA Program Integrity require that the LME-MCO complete preliminary review of allegations to determine if:
- The allegation can be substantiated
- The actions of the Provider meet the definitions of Provider Abuse found in 10A NCAC 22F.0301 or Provider Fraud found in N.C.G.S. 108A-63
- The issues identified require actions on the part of DMA up to and including referrals to law enforcement.

(2) The LME-MCO shall maintain a log of Provider Cases Referred to DMA Program Integrity. The log shall include, at a minimum, the following information:
- Provider Name
- Provider NPI Number
- Nature of Complaint/Issue/Problem
- Name and Phone number of LME-MCO Staff Analyst/Investigator for this case
- Date Review Opened
- Date Review Closed
- Findings of Review
- Date Sent to Program Integrity

(3) Any Provider reviews referred to Program Integrity shall be identified by the Provider Name, Provider NPI Number (Individual or Group practice), or the Medicaid Provider Federal Tax Identification Number (Corporations consisting of Multiple Individuals or Groups). The referral package shall consist of all original case documents obtained and maintained by the LME-MCO as part of their case review. These documents shall minimally include:
- "LME-MCO Referral to DMA Program Integrity" cover sheet
- Summary letter by the LME-MCO Staff Analyst/Investigator, detailing issues and findings; reasons for referral to Program Integrity, and recommendation for what LME-MCO believes to be appropriate sanction/action for this Provider.
- All documents related to this case review including but not limited to:
  - Provider Name
  - Provider NPI Number
  - Provider medical/financial records obtained by LME-MCO
  - LME-MCO generated reports on Provider
  - Phone call log/list related to this review
  - Endorsement or POC documents used in review
  - Letters sent to or received from Provider

The LME-MCO shall have the appropriate licensed clinicians and administrative staff involved in clinical decision making available upon request to participate in any appeal process resulting from LME-MCO referrals to Program Integrity. The LME-MCO shall

have the appropriate licensed clinicians or administrative staff available upon request to participate with the Department in developing ongoing post-payment review tools and processes to address all enhanced services.

LME-MCO's are required to conduct an inquiry and take appropriate action in response to Quality of Care and Health and Safety issues reported to the LME-MCO by DHHS when DHHS receives these concerns from a state or local funding, regulatory or enforcement agency, an agency of DHHS, an agency of the federal government, or a national accreditation organization.

7.2.8. Wait List For Innovations Waiver Service Requests

The LME-MCO shall maintain a list of individuals wishing to be considered for participation in the NC Innovations Waiver and provide it to the DHHS upon request. The LME-MCO shall determine the priority of need by completing the uniform Prioritization Tool with all individuals presenting to the LME-MCO requesting DD services, within 60 days of the individual presenting to the LME-MCO. When notified by DHHS that additional funding is available within the NC Innovations Waiver(s), the LME-MCO shall notify case managers of the most acutely in-need individuals in order to process the eligibility determination requests.

The LME-MCO shall assist in the completion of the Level of Care Determinations. The LME-MCO shall assist in transition planning for Money Follows the Person (MFP) waiver recipients

7.3. Care Coordination

7.3.1. Care Coordination for Consumers without a Clinical Home

The LME-MCO shall provide care coordination services for persons in need of MH/DD/SA services who are being discharged from state facilities, community hospitals and emergency departments, and crisis services who do not have a connection with a clinical home provider. The LME-MCO has the responsibility to ensure that staff is available for participation at the annual Plan of Care meetings for consumers from their catchment area who reside in a Developmental Center and are appropriate for community placement. The LME-MCO shall ensure that consumers who are being discharged from state facilities or who have been provided services in inpatient hospital units, facility based crisis services, non-hospital medical detoxification services, and mobile crisis management services have a scheduled appointment with a community provider within 7 calendar days of discharge. The LME-MCO shall ensure that consumers who do not attend scheduled appointments are contacted to reschedule services within 5 calendar days.

7.3.2. Care Coordination for High Cost/High Risk Consumers

The LME-MCO shall identify and provide care coordination services for high cost and/or high risk consumers who do not qualify for Medicaid including but not limited to Medicaid recipients. Until such time as the Commission adopts another definition by rule, a “high risk consumer” means a person who has been assessed as needing emergent crisis services three or more times in the previous 12 months. This definition includes persons requiring MH/DD/SA services who have been discharged from a DHHS state facility, local community hospital or specialty hospital, hospital emergency department, facility based crisis service, non-hospital medical detoxification service, mobile crisis management service, crisis respite service, or other crisis service. Until such time as the Commission adopts another definition by rule, a “high cost consumer” means a person whose treatment plan is expected to incur costs in the top twenty percent (20%) of expenditures for all consumers in a disability group.” This standard shall be applied separately to each of six age/disability groups in order to identify “high costs consumers” in each of 6 age/disability groups. This includes involvement in Person Centered Planning, facilitating appropriate connections to primary health care services through Community Care of North Carolina, the Health Department, or other physical healthcare providers. For children, this responsibility includes participation in Child and Family Teams.

7.3.4. Care Management for Medicaid Recipients with Unstable Medical and MH/SA/DD Diagnoses with CCNC

The LME-MCO shall work with local CCNC networks to manage the enrollees with unstable medical and MH/SA/DD diagnoses. The LME-MCOs shall sign data sharing agreements (Attachment V) with the CCNC Informatics Center. The LME-MCO is responsible for Medicaid recipients with Medicaid County of enrollment / eligibility in their catchment areas. The LME-MCO and CCNC shall develop shared crisis plans per the four quadrants. LME-MCO care managers shall work closely with primary care providers to insure coordinated care. LME-MCO care managers shall conduct health risk assessments and incorporate them into the plan of care.

The LME-MCO and CCNC networks will meet regularly (at least quarterly) to develop and manage local processes for:

1. Assuring access to services and integrated care for those with co-morbid (medical and behavioral) conditions
2. Coordinating care, including referrals, patient hand-offs, and meaningful health information exchange
3. Reporting metrics
4. Identifying opportunities for co-location of behavioral and primary care providers and to support new practice models.

The following represents LME-MCO responsibilities for Medicaid Recipients with Unstable MH/SA/DD Diagnoses:

Area of Accountability	LME-MCO Responsibility
Inpatient admit at a State MH Facility	Coordination of MH/DD/SA discharge services
Inpatient admit at any facility for MH/DD/SA diagnoses	Coordination of MH/DD/SA discharge services
Persons assessed as needing emergent crisis services 3 or more times in the previous 12 months Includes facility-based crisis, mobile crisis, ED, inpatient, state hospital, ADATC 3 times is defined in episodes, not days. Episode includes all related crisis services from the start of that crisis to the point of resolution (ex; person has mobile crisis contact, than admitted to FBC, then on to state hospital. This = 1 episode)	Care coordination services and patient education around appropriate ED use and patient centered plan to address identified emergent needs.
Patients detained in ED facilities awaiting commitment	Highly contingent upon notification by Hospital and willingness to transfer/discharge LME-MCOs will work with their local hospitals to insure the LME-MCO is notified when a person presents at the ED under commitment,
ED Prevention	Plan and Implement ED diversion strategies with other key community partners
Crisis Facilities (identified by facility based crisis code)	Provision of crisis stabilization services and linkage to community services and supports
NCQA standards for complex case management	“Apply relevant principles outlined in NCQA’s Case Management Standards to address the complex needs of individuals in Quadrant 4”

Four Quadrant Integration Model

QUADRANT I (LOW Physical Health (PH), LOW Behavioral Health (BH))

Receive primary care for prevention/early identification of physical and behavioral needs.

May have brief encounters w/specialists (physical or behavioral)
All providers communicate/link w/Medical Home (could be BHP integrated into medical home)

QUADRANT II (LOW PH, HIGH BH)

LME-MCO Hi-Risk Definition

- *MH/DD/SA* inpt. w/out therapist or enhanced MH Service Provider*
- Received emergent crisis services greater than or equal to 3 episodes in past 12 months

Should be linked through LME-MCO to BHP (including CABHAs)
LME-MCO responsibilities:

- Identify BHP for CCNC
- Link unassigned clients to qualified BHP
- Provide Screening, Triage, and Referral (STR), crisis linkage, system of Care Coordination until linked with BHP
- Upon request provide consultation for CCNC and/or PCP re: behavioral health conditions that place client at risk (including but not limited to psychotic disorders, mood disorders, anxiety disorders, etc.)
- Monitor contracts with BHP's that require basic medical screening questions, linkages, and communication w/medical home on key clinical information
- Through monitoring ensure BHP includes:
  - linkage w/medical home
  - Annual exams/medical needs (i.e. labs, medications, referral and follow up) incorporated into person-centered plan of care and into crisis plan

CCNC responsibilities (When patients are identified):

- Referral to LME-MCO and existing BHP if adverse high risk events (i.e. inpatient admission),
- If BHP is unknown, referral to LME-MCO based on local protocol
- If patient enrolled in CCNC medical home and upon request, identify medical home for LME-MCO and/or BHP via Patient Care Team Summary from Provider Portal.
- Upon request, provide consultation/cross trainings for LME-MCO and/or BHP on medical conditions (chronic disease, medical factors that place client at risk).
- *If client unwilling to engage w/mental health services*
  - *Notify Primary Care Provider (PCP) and encourage follow up*
  - *Provide patient and PCP information on accessing STR and Mobile crisis services*
  - *As requested by PCP, support/reinforce PCP's plan of care*
  - *If safety and support system issues are identified, notify PCP, LME-MCO, and/or BHP*

QUADRANT III (HIGH PH, LOW BH)

CCNC Hi-Risk Definition:
Identified by CCNC and/or LME-MCO as Aged, Blind, Disabled (ABD) Medicaid category and high risk as defined by **2 or more chronic conditions**, (physical and/or behavioral) **and is unstable**, as by evidence of 2 or more of the following:

- *1 or more inpt. admit w/in past 6 months*
- *3 or more ED visits w/in past 6 months*
- *8 or more Rx over past month or 24 over past 3 months*
- *3 or more outpt. Providers in past 6 months*
- *No PCP visit w/in past 12 months*
- *2 or more ADL deficits requiring hands on assistance*

Additional clinical/social/mental health information supports unstable conditions
Should be linked w/medical home

CCNC responsibilities:

- If patient chooses, if not assigned to CCNC medical home, refer to DSS who will address if patient is eligible for CCNC medical home, who will educate patients on options and who will help enroll them in CCNC medical home.
- If patient enrolled in CCNC medical home, identify medical home for LME-MCO and BHP.
- Provide Care Coordination services for clients in medical crisis, until stable and linked w/medical home
- Upon request provide consultation/cross trainings for LME-MCO and/or BHP re: medical conditions that place client at risk
- With patient collaboration, functions of CCNC Care Coordination can include:
  - Perform a comprehensive health assessment and home visit (per patient's availability)
  - Implement medication reconciliation with PCP and network clinical pharmacist to assure continuation of needed therapy following discharge
  - Ensure follow up appointments with Primary Care Practice
  - Provide patient education about disease states to include medication adherence, prevention, and risk factor reduction
  - Promote patient self management of the medical illness.
  - Provide transitional Care Coordination from hospitals for the high-risk, high-cost, high-acuity population
  - Assist providers with coordination for high-risk, high-cost, high-acuity population
  - Advocate for recipients to ensure that recipients receive appropriate evidence-based care for identified medical conditions

LME-MCO responsibilities (When consumers are identified):

- Referral to PCP if adverse high risk events (i.e. inpatient admission), if PCP is unknown notify DSS
- Referral to both PCP and CCNC (when in CCNC medical home) for clients meeting high risk
- Identify for CCNC the existing BHP. If unassigned, link to BHP
- Upon request provide consultation/cross training for CCNC/PCP on BH conditions (including but not limited to psychotic disorders, mood disorders, anxiety disorders, etc.), evidenced based guidelines, medications, other MH/DD/SA factors that place client at risk (i.e. isolation, poor hygiene and self-care, low medication compliance as well as family/care-giver burnout, etc.)

QUADRANT IV - HIGH PH AND HIGH BH

Likely require both specialty medical and BH clinical care and is at increased risk. (e.g. pt. w/CHF, DD, COPD, Schizophrenia)

Joint responsibilities of LME-MCO's and CCNC:

- Both LME-MCO's and CCNC retain all responsibilities outlined in Quadrant II and III above, including identification of pts meeting High Risk definitions.
- CCNC and LME-MCO provide joint Care Coordination services or consultation when medically appropriate or indicated.
- If client declines BH services and is high risk or has an adverse event, CCNC and LME-MCO jointly provide Care Coordination services as appropriate
- Collaboration between LME-MCO and CCNC to ensure clients receive evidenced based behavioral health and physical health care.
- CCNC and LME-MCO will encourage, support and facilitate communication between PCP and BHP regarding medical management, shared roles in the care and crisis plan, exchange of clinically relevant information, annual exams, and coordination of services, case consultation and problem solving.

7.3.5. Deaf Services

The LME-MCO's will collaborate with the state and recognize regionally-based specialty providers who deliver mental health and substance abuse services to deaf consumers who use sign language. The state funded positions contracted out to these specialty providers deliver services that include the provision of Diagnostic Assessment, Person Centered Planning, individual/group/family therapy, Telepsychiatry Professional Services, and consultation/technical assistance as staff schedules and qualifications permit.

7.3.6. Outpatient Commitment

The LME-MCO shall provide care coordination services for its consumers who are under an outpatient commitment order. This includes maintaining up-to-date records on each consumer in the catchment area with an outpatient commitment order including the name or names of their treatment provider(s) and documentation that the LME-MCO frequently and routinely contacts the service provider(s) to verify the consumer's compliance with the outpatient commitment order. If the LME-MCO determines that the consumer has failed to comply or clearly refuses to comply with all or part of the prescribed treatment, the LME-MCO shall report such failure as required by G.S. § 122C-273 and take action as necessary.

7.3.7. Cross Area Service Programs (CASP)

The LME-MCO shall ensure the continuing identification, use and tracking of Cross Area Service Program (CASP) funding and services as approved by the NC General Assembly and designated in DMH/DD/SAS allocation letters. The CASP is designated by the DMH/DD/SAS to receive specialty funding to provide comprehensive regional or statewide services across multiple LME-MCOs. Services are directed through a provider entity designated by the DMH/DD/SAS and approved by the LME-MCO to serve the

needs of an identified consumer population. Services are targeted to eligible designated consumers and their families in an identified region or regions, but available to all eligible consumers and their families statewide as capacity allows.

7.3.8. Professional Liability Insurance

The LME-MCO, operating a PIHP, shall maintain professional liability insurance for itself and its professional staff with limits of at least ($1,000,000) per occurrence and at least ($3,000,000) in the aggregate throughout the terms of the contract by the time the contracts are signed.

7.4. Community Collaboration

7.4.1. Community Relationships

The LME-MCO shall establish and maintain effective collaborative working relationships with other public agencies, health care providers, and human services agencies within their catchment area for the benefit of consumers. These include but are not limited to: Departments of Social Services, Local Health Departments, community hospitals, housing and homeless services agencies, vocational rehabilitation and employment agencies, domestic violence agencies, jails, detention centers, training schools, prisons, public schools, colleges, and universities, law enforcement, courts, corrections agencies Juvenile Court Counselors, Community Care Networks and other primary healthcare providers, including rural and community health centers and Federally Qualified Health Clinics. The LME-MCO shall ensure that other agencies that serve consumers likely to need mental health, developmental disability and substance abuse services are provided with information on the services available in the community, how consumers may access services, and how they may be assisted in navigating the service delivery system. The LME-MCO shall make available to these community partners posters and other materials that will assist consumers in accessing services.

7.4.2. Social Marketing Plan

The LME-MCO shall develop and implement a plan to engage in public awareness campaigns designed to reduce the stigma attached to disabilities, increase the visibility of the LME-MCO and MH/DD/SAS providers in the community, promote prevention, wellness and recovery activities, and support and encourage the use of evidence-based practices. The plan shall include a component designed to increase competitive employment opportunities for consumers.

7.4.3. Natural and Community Supports

The LME-MCO shall work with other public, faith-based, and non-profit organizations to increase the service options available to non-target population individuals and to increase the availability of natural and community supports for consumers. The LME-MCO shall pursue opportunities to increase consumers' access to free or low cost medications, affordable housing, employment and other supports and services.

7.4.4. Emergency Response

The LME-MCO shall participate in the development of community response plans and shall work with its providers to ensure adequate capacity to meet the needs of the community in the event of a community-wide disaster or emergency situation.

7.4.5. Development of Housing Opportunities for Consumers

The LME-MCOs' DMH/DD/SAS-funded housing coordinator/specialist position shall be dedicated solely to housing activities, while working with the DMH/DD/SAS and DHHS housing staff to increase housing opportunities throughout the region to which the coordinator is assigned. Housing resource development functions include but shall not be limited to:

(1) Serve as Lead Agency in Key Program local Housing Support Committees to ensure DMH/DD/SAS tenants have the support services they need in addition to the affordable housing.

(2) The Housing Specialist will review the current Housing Plan and update accordingly taking into consideration assessment of gaps noted during the FRA gaps assessment process and using the attached document as guidance to update the Housing Plan.

(3) Work with other agencies to identify and secure housing and support service funding opportunities from private, city/county, state, and federal sources.

(4) See Attachment I A - LME Housing Coordination Activities

7.4.6. Development of Employment Opportunities for Consumers

The LME-MCO shall work with the DMH/DD/SAS and the Division Vocational Rehabilitation to foster relationships with their local Vocational Rehabilitation (VR) office and the VR Supported Employment vendor agencies, as well as Community Rehabilitation Programs to increase employment opportunities in accordance to the NC Strategic Plan.

7.4.7. Community Prevention Services

The LME-MCO shall provide leadership, technical assistance, and participation in community-wide coalitions and other initiatives to discourage inappropriate access, misuse, and abuse of legal and illegal substances (alcohol, tobacco, and other drugs) by minors and adults and to improve the emotional health and well-being of individuals in their catchment area.

The LME-MCO shall support Synar Amendment, Enforcing Underage Drinking Laws, NC Controlled Substance Reporting System, and other initiatives to educate and prevent underage access and use of tobacco and alcohol products and the misuse and abuse of prescription drugs.

The LME-MCO shall support community-wide efforts to educate and prevent stress-related conditions and concerns of military personnel and their families.

The LME-MCO shall support community-wide efforts to educate and prevent other MH/DD/SA issues, including Traumatic Brain Injury (TBI), suicide, violence and trauma, communicable disease risk, Fetal Alcohol Spectrum Disorders (FASD), and health disparities for Native Americans and other underserved racial, ethnic, cultural, and linguistic minorities.

The LME-MCO shall support community-wide efforts to educate that MH/DD/SA-related physical health symptoms and conditions, such as cardiovascular, lung disease, obesity, diabetes, and asthma are exacerbated by co-occurring MH/DD/SA conditions.

7.5. System of Care

7.5.1. System of Care Coordinator

The LME-MCO shall have at least 1.0 FTE staff member fully dedicated to System of Care Coordination. This person(s) is staff to the Community Collaborative comprised of families, child, youth and family serving agencies and community partners; ensures fidelity to the process of Child and Family Teams for Person-Centered Planning; provides System of Care training and technical assistance to the provider community; and, with local collaboratives, identifies and tracks outcomes to ensure the effectiveness of System of Care efforts.

LME-MCO System of Care (SOC) Coordinators shall be involved in CFT meetings with Medicaid recipients as needed prior to placement in Level III/IV residential care and PRTF. SOC Coordinators shall not discourage Medicaid consumers from seeking prior authorization for services the consumer or the consumer's treating provider believes are medically necessary.

7.5.2. Community Collaborative

The LME-MCO shall have a community collaborative comprised of: (1) family members of a child or youth being served or who was once served in the system (2) child, youth and family serving public and private agencies; and (3) community partners to support System of Care practices and principles of family-driven and youth-guided care, individualized and community-based services, interagency collaboration, and cultural competence.

8.0 Consumer Affairs and Customer Service

8.1. Supports to CFAC and the Human Rights Committee

The LME-MCO shall maintain and provide competent, qualified staff and support to the CFAC and Human Rights Committees to fulfill the functions of these committees.

8.2. Consumer and Family Outreach and Education

The LME-MCO shall provide outreach, education and customer service to consumers and families on issues such as rights protection, complaint processes, advocacy and

empowerment opportunities, evidence-based practices and service authorization guidelines. The LME-MCO shall publicize that injection drug users and substance-abusing pregnant women have program admission priority.

8.3. Assistance to Consumers

The LME-MCO shall provide persons with a disability a Handbook that assists them to understand the various parties in the public system, their roles and responsibilities. The LME-MCO shall provide assistance to consumers and families in understanding and fully accessing the public MH/DD/SAS delivery system and other public agencies. The LME-MCO shall encourage self-direction and recovery and assist consumers and families in addressing barriers to care and choosing a provider. The LME-MCO shall maintain, publish and staff a toll free customer service line during normal business hours. A customer service staff person shall respond to inquiries within one business day.

8.4. Consumer Complaints and Appeals

The LME-MCO shall respond to complaints and process appeals from consumers in accordance with state rules and DHHS processes and procedures. The LME-MCO shall report all required information regarding critical incidents and consumer complaints and appeals to DHHS in the manner and timeframes outlined in policy and shall report aggregate information on incidents, complaints and appeals to the Board, the human rights committee and CFAC quarterly. If a satisfactory outcome is not reached with the LME-MCO, in circumstances where an appeal is appropriate under G.S. 122C-151.4 and G.S. 122C-143 B – 147(a)(1)(9) the consumer may also appeal to the MH/DD/SA appeals panel.

9.0 Quality Management

9.1. Identification and Remediation of Problems

The LME-MCO shall have a process for timely identification, response, reporting, and follow-up to consumer incidents and stakeholder complaints about service access or quality. The LME-MCO shall ensure that all LME-MCO and provider staff are fully compliant with critical incident and death reporting laws, regulations, and policies and event reporting requirements of national accreditation organizations. The LME-MCO shall review, investigate, and analyze trends in critical incidents, deaths, and take preventive action to minimize their occurrence in accordance with DHHS policy.

9.2. Management Reports

The LME-MCO shall produce reports referenced in Attachment II 2.0 and use them for planning, decision making, and improvement. The reports shall analyze and summarize patterns and trends related to consumers, providers, and LME-MCO operations, including but not limited to:

(1) Consumer trends: critical incidents, client rights, personal outcomes, use of state facilities and local hospitals, use of emergency and crisis services and hospital

emergency departments (as provided by DHHS), service utilization rates, and perceptions of care;

(2) Local service system trends: service capacity, access to care for each population group and underserved groups, barriers to care, local system performance, assessments of provider quality, results of audits and monitoring activities, technical assistance and trainings, and use of evidence-based practices;

(3) LME-MCO operations: management of state funds, trends in volume and cost of services per consumer, Screening, Triage, and Referral processes, response to consumer requests for service, complaint response, and choice of providers.

(4) Access to primary care: linkage to medical home and evidence of a preventative health exam within the past 15 months.

(5) Service patterns and costs for high cost / high risk individuals and Medicaid recipients with unstable medical and MH/DD/SA diagnoses.

9.3. Consumer Data

The LME-MCO shall ensure that its providers collect and submit complete information on consumers, as required by DHHS policy. The LME-MCO shall provide information, training, and support to LME-MCO staff, CFAC members, and its providers to encourage their review and use of data collected by providers, the LME-MCO and DHHS for improvement of service quality and effectiveness.

The LME-MCO shall insure full compliance of its staff and its providers to ensure that they are fully compliant with security, privacy, and confidentiality of all individually identifiable health information in conformance with HIPAA, 42 CFR, Part 2, and G.S. 122C-52 and other state and federal laws.

9.4. Quality Improvement

The LME-MCO shall establish a quality management committee to identify and address opportunities for improvement of LME-MCO operations and the local service system. The committee shall review the LME-MCO and provider responses to individual and system concerns and problems and address opportunities for improvement of LME-MCO and provider operations and the local service system. The committee shall have a process for reviewing and incorporating trends (identified in Section 9.2 above) and input from providers, consumers, family members, and other stakeholders into its decisions. The LME-MCO shall conduct a minimum of three (3) quality improvement studies. The summaries of these studies shall be provided to the local Board, the local CFAC, and, on request to DHHS.

To fulfill the LME-MCO responsibilities for managing the care of Medicaid recipients with unstable medical and MH/DD/SA diagnoses, the LME-MCO's quality improvement studies shall, at a minimum, be designed to:

(1) reduce the need for psychiatric inpatient admissions to community hospitals for Medicaid recipients with primary MH/DD/SA diagnoses, by ensuring provision of appropriate levels of community-based care; and

(2) reduce the number of Medicaid recipients who require three or more episodes of crisis service use, including facility based crisis, mobile crisis, and emergency department services, by ensuring appropriate crisis planning and community-based services.

ATTACHMENT I A
LME Housing Coordination Activities

Serve as Lead Agency in Targeting Program, and the Housing 400 Initiative to ensure DMH/DD/SAS tenants have the support services they need in addition to the affordable housing:

- Follow the Targeted Unit guidelines as the Local Lead Agency.
- Follow-up on Targeted Unit tenant issues.
    - Return call to property manager after contact has been established / attempted with Referral Agency to notify if contact was made.
    - Notify DHHS Targeted Program Manager in the event that the referral agency has closed, or is stating they will not follow procedure and reach out to their tenant.
- At least once a month, initiate proactive contact with property management for general inquiries regarding Targeted Unit tenants, and as appropriate visits with property management.
- Coordinate with regional Targeted Unit Coordinator, or Field Operations Manager, to schedule meetings with all local property managers, and all lead agencies at least twice a year to establish relationships and address issues as needed.
- Coordinate with regional Targeted Unit Coordinator or Field Operations Manager in order for staff to be available at housing meetings to discuss the Targeting Program as appropriate.

Actively participate in local Continuum of Care (U.S. Department of Housing and Urban Development housing programs that provide units for DMH/DD/SAS consumers who are homeless) by engaging in activities that support the expansion of housing opportunities to ensure DMH/DD/SAS consumers have access to Continuum of Care (CoC) housing units:

- Work to create or join established Continuum of Care to support, and take leadership role to apply for federal funding, and other activities to meet the needs of persons experiencing homelessness.
- Develop partnerships, and work collaboratively by having regular contact with local shelters and homeless providers (i.e. PATH and SOAR caseworkers), other housing and service advocates, local officials, community stakeholders including North Carolina Coalition to End Homelessness.
- Regularly attend and actively participate in local CoC / regional committee meetings.
- Working collaboratively with North Carolina Coalition to End Homelessness, and local partners to implement local 10-Year Plan to End Homelessness efforts.
- Encourage community partners to participate in local CoC meetings.
- Educate the community as it relates to the work of the CoC.
- Encourage Balance of State (BoS) participation
- Create or join Regional Committee of BoS when appropriate

Develop and annually update a Strategic Housing Plan that includes an inventory of

local, existing housing for DMH/DD/SAS consumers; the housing needs of DMH/DD/SAS consumers; strategies for filling the gap between existing housing and housing needs; barriers to implementing those strategies; and means for assessing implementation of the Strategic Housing Plan:

- Develop and maintain an inventory of housing stock inclusive of affordable, existing permanent supportive housing units inclusive of: (i.e., housing type, population served, capacity total and number of available units).
- Make a determination of barriers to consumers accessing current housing stock (i.e., waitlist status, practices, and eligibility requirements).
- Make efforts to include consumers in your planning process to identify. MH/DD/SAS consumers with housing need (i.e., conduct consumer survey to ascertain their housing needs and preferences, number disabled persons, their income info, persons receiving SSI income, number on waiting list for housing).
- Utilize homeless data resources, and 10-Year Plan to End Homelessness (i.e., Point-In-Time count, HUD Gaps Analysis).
- Identify persons to be added to your housing need count that are considered homeless, and are at risk of homelessness with living situations including (i.e., street, shelter, transitional housing, hospital, jail, prison, doubled-up, aged care givers & persons living in congregate settings that could and desire to live independently with access to appropriate supports).
- Collaborate with internal and external stakeholders in developing implementing strategies.
- Identify community services and supports needed for individuals residing in housing units.
- Determine the number and type(s) of housing needed.
- Partner with private and non-profit developers to identify new funding opportunities as part of the planning process to expand the supply of affordable housing units.
- Develop strategies for implementation of housing objectives / goals, and review Housing Plan at least annually.
- Coordinate advocacy activities inclusive of educating local officials and stakeholders of the housing needs for your catchment.

Send a representative to the four annual meetings of Housing Specialists that are offered by the DMH/DD/SAS Housing Specialist:

- Attend or have representation (via phone or in person) and actively participate in at least three of the (4) scheduled Housing Specialists' meetings.
- Adhere to deadlines in the completion of both Quarterly and Annual Report of Activities, requested by the DMH/DD/SAS Housing Specialist.

Educate and be a resource of support to MH/DD/SAS professionals, advocates, consumers, families and service providers in identifying, accessing and maintaining affordable housing, regarding the N.C. Landlord-Tenant and Fair Housing laws, and on negotiating reasonable accommodations:

- Available to work collaboratively with MH/DD/SAS professionals and advocates to identify and secure housing.

- Make available in multiple venues where Service Providers, and other stakeholders convene, information to identify housing resources, expand knowledge of eligibility requirements for difference housing programs, how to access affordable housing resources, information to increase awareness of the Fair Housing Act, Americans with Disabilities Act, Landlord and Tenant Rights, barriers associated with Not In My Back Yard (NIMBY)ism, and information to reduce stigma associated with mental illness, intellectual developmental disabilities and substance use disorders.
- Attend at least one Provider's meeting within a year
- Offer to provide technical support to Service Providers and Consumers on accessing housing, and the process of making Reasonable Accommodation request.
- Available when needed to assure consumers are linked back appropriately to Service System when housing is at risk of becoming destabilized.
- Coordinate / participate in housing meetings at least quarterly.

Develop a positive working relationship with local public housing authorities and HUD Section 8/Housing Choice Voucher administrating agencies to improve access and increase the supply of these resources:

- Regularly, strategically seek out means of establishing / nurturing partnerships with PHAs.
- Gain knowledge of, and seek out ways to support PHAs' supportive housing plan.
- Stay abreast of, and plan to attend at least one board meeting annually at PHA.
- Work toward the ability to include PHAs in CoC, 10-Year Plan, and other local housing meetings.
- Work toward the ability to work collaboratively with PHA leadership to coordinate housing efforts, to educate on CoC HUD funded programs, discuss local Fair Housing issues, rental trends, etc.

Establish partnerships with other local, affordable housing and MH/DD/SAS advocates to improve access, and increase the supply of resources for MH/DD/SAS consumers:

- Meet with property managers, and provide training opportunity for Landlords on supportive housing.
- Maintain regular communication with area housing agencies, and supportive housing advocates
- Gain knowledge of and strive to work collaboratively with local non-profits, developers, MH/DD/SAS stakeholders including NC Oxford House to encourage and support development of new supportive housing.
- Complete Inspections of newly opened Oxford Houses as made known within two months.
- Gain knowledge of and strive to work collaboratively with local MH/DD/SAS advocates to encourage and support development of new supportive housing (participating jurisdiction, affordable housing providers, local Coalition, Center for Independent Living, etc.).

Develop and maintain an internal wait list for consumer referrals to housing resources

that have referral relationships with the LME:

- Work collaboratively to support LME's efforts to track housing outcomes of consumers transitioning out of congregate settings into the community.
- Maintain ongoing communication as it relates to housing resources (i.e., updates such as changes in unit availability, new units, and the total number of units).

Work with other agencies to identify and secure housing and support service funding opportunities from private, city/county, state, and federal sources:

- Work with existing partnerships to establish additional resources (i.e. additional vouchers, housing opportunities, and programs).
- Identify potential housing development partners (i.e. Dept. of Social Services, city officials, faith community, public housing agencies, jail, prison, psychiatric hospitals, mental health, substance abuse, Intellectual Developmental Disability professionals and advocates).
- Strive to enhance working knowledge of funding sources and how to successfully secure and utilize to increase the supply of permanent supportive housing.
- Offer to provide technical assistance and support to identified agencies applying for state and federal funding opportunities (i.e. justification of need, providing data and information as it relates to available support services).

ATTACHMENT II
Performance Expectations

1.0 Process for Monitoring and Reporting of Local System Quality and Compliance

1.1. Quarterly Reports on Performance

The DHHS shall evaluate the overall performance of the LME-MCO system through review of each management function, compliance with reporting requirements, and through statewide measures of service quality, as described in this Attachment. The DHHS shall calculate and publish quarterly the LME-MCO's performance on each indicator listed in Sections 2.1 and 3.0 through 3.7 below.

1.2. Correction of Published Errors

If the LME-MCO believes information in the publication to be erroneous, the LME-MCO shall contact the designated DHHS representative (DMH LME-MCO Liaison) within 30 days of the publication of data referenced above to request a data review. The LME-MCO shall provide evidence to support the LME-MCO's request and to assist the DHHS to make a determination concerning the request. Acceptable evidence shall include documentation that information that was submitted to the DHHS by the end of the month prior to the publication date was erroneously included or excluded.
The DHHS shall provide a written response to the LME-MCO within 30 days of receiving the LME-MCO's request. If the DHHS agrees to correct the error, the DHHS response shall provide details concerning the error and revision. The DHHS shall publish a notice with the corrected data, when an error is determined to be the responsibility of the DHHS. If an error that is the responsibility of DHHS jeopardizes the LME-MCO's single stream funding eligibility, the DHHS shall reassess the LME-MCO's eligibility based on the corrected data.

2.0 Functional Component Indicators

The DHHS shall monitor the LME-MCO's implementation of each management function on an ongoing basis. A fully functioning LME-MCO shall have in place all of the components of each management function listed in the table below. The DHHS shall use the essential components to evaluate the LME-MCO's performance of each function.

Function	Components
General Administration and Governance	(1) Active Board that meets at least (6) times a year; (Attachment I, 1.2) (2) Active CFAC that meets at least six (6) times a year; (Attachment I, 1.3) (3) Qualified CEO that meets required qualifications per NCGS 122C-121(d); (Attachment I, 1.4) (4) Satisfaction of SPMP (FFP) requirements; (Attachment I, 1.5) (5) Qualified clinical staff in all three disability areas (Attachment I, 1.5)
Business Management and Accounting	(1) Management of IPRS funds to reimburse providers for authorized, delivered, and billed services; (Attachment I, 2.1) (2) Quarterly written reports including a balance sheet provided to the Board and CFAC (Attachment I, 1.2 & 2.2) (3) DHHS approved LME-MCO contracts templates with providers (Attachment I, 2.3) (4) Submission of Reports to DHHS as required; (Contract 10.0 (7)
Information Management	(1) Fully functioning IT infrastructure, HIPAA compliant, electronic connection to State IT, and capability to communicate with providers electronically; (Attachment I, 3.1) (2) Submission of consumer screening, admissions, updates, discharges, and eligibility data (Attachment I, 3.3) (3) Analysis of services authorizations and claims data; (Attachment I, 3.5) (4) Timely response to data requests; (Contract 10.0 (7) (5) Informative, user-friendly website with current (evergreen) information. (Attachment I, 3.7)
Claims Processing	(1) Process for prompt payment of claims (Attachment I, 4.1) (2) Process to identify all relevant payer information for each consumer; (Attachment I, 4.1) (3) Process to pursue all applicable first and third party payments for services; (Attachment I, 4.2)
Provider Relations	(1) *Annual assessment of community need and provider capacity with updates as needed reported to Board & CFAC; (Attachment I, 5.1)* (2) *Minimum number of provider agencies for every service necessary to ensure consumer choice; (Attachment I, 5.2)* (3) *Process for timely credentialing and enrollment requirements; (Attachment I, 5.4.1 & 5.4.2)* (4) *Appropriate provider manual, trainings and technical assistance; (Attachment I, 5.3 & 5.6)* (5) *Process for ongoing evaluation and monitoring of provider quality and compliance with data submission requirements; (Attachment I, 5.5)* (6) *Process for resolving provider complaints. (Attachment I, 5.7)*

Function	Components
Access / Screening, Triage and Referral	(1) Toll-free phone line; (Attachment I, 6.1) (2) 24-hour access 365 days a year; (Attachment I, 6.1) (3) Calls answered within 30 seconds by qualified professional; (Attachment I, 6.1) (4) TTY and/or Relay capability and foreign-language interpreter; (Attachment I, 6.1) (5) Ability to schedule appointments with an appropriate provider within 24 hours of initial contact; (Attachment I, 6.1) (6) Report to Board and CFAC on access patterns and trends; (Attachment I, 1.2) (7) Screening consumers using the standard state form or all of the elements of the standard form. (Attachment I, 6.2)
Service Management (UM, Care Coordination, Community Collaboration, and SOC)	(1) Published Funded Consumer Benefit Plan; (Attachment I, 7.2.2) (2) Implementation of approved LME-MCO crisis services plan; (Attachment I, 7.2.3) (3) Process for review of person-centered plans; (Attachment I, 7.2.4) (4) Service authorization decisions within required timelines; (Attachment I, 7.2.5) (5) Notification to consumers of rights and appeals regarding LME-MCO service authorization decisions; (Attachment I, 7.2.6) (6) Audit and Post-payment review of services by licensed staff; (Attachment I, 7.2.7) (7) Management and prioritization of requests for NC Innovations Waiver services; (Attachment I, 7.2.8) (8) Coordination of care for high cost/high risk consumers and consumers without a clinical home; (Attachment I, 7.3.1 & 7.3.2) (9) Active collaborative relationships with CCNC providers, including use of data from the CCNC Informatics Center (Attachment I, 7.3.4) (10) Active collaborative relationships with other human service agencies; (Attachment I, 7.4.1 & 7.4.3) (11) Activities to encourage use of natural and community supports; (Attachment I, 7.4.3) (12) Full-time System of Care coordinator; (Attachment I, 7.5.1) (13) Designated staff to coordinate prevention services, deaf services, and development of housing opportunities (if applicable); (Attachment I, 7.4.7, 7.3.5, & 7.4.5) (14) Quarterly Report to the Board on service utilization patterns. (Attachment I, 1.2)

Function	Components
Consumer Affairs and Customer Service	(1) A customer service staff person shall respond to inquires within one business day. (Attachment I, 8.3) (2) Outreach/education activities and materials (English & Spanish); (Attachment I, 8.2) (3) Consumer Manual; (Attachment I, 8.3) (4) Timely response and resolution (disposition) to consumer questions and complaints; (Attachment I, 8.4) (5) Staff support to the CFAC and Human Rights Committees; (Attachment I, 8.1) (6) Report to Board, human rights committee, CFAC and DHHS on consumer incidents, complaints, appeals, and satisfaction with services at least quarterly. (Attachment I, 1.2 & 8.4)
Quality Management	(1) Timely identification and remediation of problems; (Attachment I, 9.1) (2) Production and review of regular management reports; (Attachment I, 9.2) (3) Collection and submission of consumer data; (Attachment I, 9.3) (4) Analysis and use of data for planning, decision making and improvement; (Attachment I, 9.4) (5) Active Quality Improvement committee; (Attachment I, 9.4) (6) Report on QI activities to Board and CFAC quarterly and to DHHS on request. (Attachment I, 1.2 & 9.4)

2.1. Compliance with DHHS Reporting Requirements

The DHHS shall calculate quarterly the LME-MCO's compliance with requirements for reporting information, as described in this contract and DHHS policies. The DHHS shall review measures to identify comparative patterns and trends in order to evaluate areas of strength and weakness in the LME-MCO's compliance. DHHS shall publish results quarterly, as described in Section 1.0 of this Attachment. The DHHS shall maintain a current listing of all reporting requirements on the DMH/DD/SAS website at http://www.ncdhhs.gov/mhddsas/performanceagreement/index.htm

3.0 System Performance Indicators

DHHS shall use the following measures to monitor the LME-MCO's performance on areas that have a direct impact on consumer care. DHHS shall review measures to identify comparative patterns and trends in order to evaluate areas of strength and weakness in the LME-MCO's performance. DHHS shall publish results quarterly, as described in Section 1.0 of this Attachment.

A standard for expected performance is assigned to each measure, based on the statewide average for the second quarter of the previous fiscal year, as reported in the

MH/DD/SAS Community Systems Progress Report, available on the DMH/DD/SAS website at http://www.ncdhhs.gov/mhddsas/statspublications/reports/index.htm. [Standards for new measures shall be based on the statewide average for the second quarter of the previous fiscal year, using the methodology that shall be applied in SFY 2011-12.] DHHS shall use performance below the expected level on one or more measures as a signal that further on-site review of the LME-MCO's functions may be needed. DHHS may use performance at or above the expected level on one or more measures to evaluate LME-MCOs' readiness to participate in specific DHHS initiatives and to determine Medicaid payments.

NOTE: The LME-MCOs have successfully achieved the goals for the measures *"Timely Emergent Care – Appointments Kept"* and *"Child Services in Non-Family Settings."* As a result, the DHHS has retired these measures and shall continue to monitor them to ensure that LME-MCOs sustain these achievements.

3.1. Prevention and Early Intervention Indicators

Rationale: Persons at risk for mh/dd/sa disorders who receive early education and intervention services are more likely to avoid debilitating impairments from these problems.

3.1.1. Selective and Indicated Substance Abuse Prevention Services

Performance Standard: The percent of persons who complete substance abuse prevention programs each quarter is equal to or greater than the statewide average for the reference period from the previous fiscal year.

Measurement: The DHHS shall calculate the number of persons who complete an evidence-based substance abuse prevention program as a percent of all persons who enroll in those programs, based on information submitted by SA prevention providers to the NC-POPS system.

3.2. Timely Access to Care Indicators

Rationale: Timely access to appropriate care is critical to protect consumer health and safety, minimize adverse consumer outcomes and promote consumer engagement in services. The timely access measures are based on Healthcare Enterprise Data Information System (HEDIS ©) measures, supported by the federal Centers for Medicare and Medicaid Services (CMS).

3.2.1. Timely Urgent Care – Appointments Kept

Performance Standard: The percent of persons starting a new episode of care who are in need of urgent mh/dd/sa services and receive their first face-to-face service (assessment and/or treatment) within 48 hours of the request for care is equal to or above the statewide average for the reference period from the previous fiscal year.

Measurement: Each LME-MCO shall report quarterly information on persons requesting urgent care and appointments offered and scheduled on a form provided by the DHHS. The DHHS shall review a random sample of urgent services annually to verify that the

information submitted is accurate. The DHHS shall match initial requests for new episodes of urgent care submitted by LME-MCOs to the Client Data Warehouse with Medicaid and IPRS claims data to determine the percent who receive a billable service by the second calendar day after the screening date. A new episode of care is defined by having no state- or federally-funded claim-based service (including paid claims, shadow claims, and claims denied for fiscal reasons) within the last 60 days.

3.2.2. Timely Routine Care – Appointments Kept

Performance Standard: The percent of persons starting a new episode of care who are in need of routine mh/dd/sa services and receive their first face-to-face service (assessment and/or treatment) within 14 calendar days of the request for care is equal to or above the statewide average for the reference period from the previous fiscal year.

Measurement: Each LME-MCO shall report quarterly information on routine care and appointments offered and scheduled on a form provided by the DHHS quarterly. The DHHS shall review a random sample of routine services annually to verify that the information submitted is accurate. The DHHS shall match initial requests for new episodes of routine care submitted by LME-MCOs to the Client Data Warehouse with Medicaid and IPRS claims data to determine the percent who receive a billable service within 14 calendar days of the screening date. A new episode of care is defined by having no state- or federally-funded claim-based service (including paid claims, shadow claims, and claims denied for fiscal reasons) within the last 60 days.

3.3. Treated Prevalence Indicators

Rationale: The public system is charged with serving NC residents who are in need of specialized mh/dd/sa services and have limited access to privately-funded services (commensurate with available resources).

Performance Standard: The percent of persons estimated to have a mh/dd/sa disability who received at least one service during the prior rolling one year period is equal to or above the statewide average for the reference period from the previous fiscal year.

Measurement:
DHHS shall analyze IPRS and Medicaid service claims data quarterly to determine the number of persons meeting the criteria for each age-disability group who received at least one disability-specific service in the past four quarters. Treated prevalence shall be calculated as the number of persons in the age-disability group who receive at least one service during the period divided by the number of persons in the LME-MCO who are estimated to need services. State population projections at the beginning of the state fiscal year are based on data from the Office of State Budget and Management. Estimates of need are based on the national prevalence estimates listed below.

3.3.1. Adult Mental Health (AMH) Services

Prevalence Estimate: According to the most recent national prevalence estimate for North Carolina, as determined by the federal Center for Mental Health Services, 5.4% of adults ages 18 and above have a serious mental illness in any given year.

3.3.2. Child/Adolescent Mental Health (CMH) Services

Prevalence Estimate: According to the most recent national prevalence estimate, as determined by the federal Center for Mental Health Services, 11% of children and adolescents ages 0-17 have a serious emotional disturbance in a given year. Because the NC public health system is responsible for serving children from birth through age 2, the prevalence estimate shall be applied to the LME-MCO's population ages 3-17.

3.3.3. Adult Developmental Disability (ADD) Services

Prevalence Estimate: The most recent national prevalence estimate, as determined by the 1994-1995 National Health Interview Survey, is that 0.79% of adults ages 18 and above have a developmental disability.

3.3.4. Child/Adolescent Developmental Disability (CDD) Services

Prevalence Estimate: The most recent national prevalence estimate, as determined by the 1994-1995 National Health Interview Survey, is that 3.2% of children and adolescents ages 0-17 have a developmental disability. Because the NC public health system is responsible for serving children from birth through age 2, the prevalence estimate is applied to the LME-MCO's population ages 3-17.

3.3.5. Adult Substance Abuse (ASA) Services

Prevalence Estimate: The national prevalence estimate for North Carolina, as determined by the most recent National Survey on Drug Use and Health, is that 19.26% of adults ages 18-25 and 6.42% of adults ages 26 and above have a substance abuse problem in any given year.

3.3.6. Adolescent Substance Abuse (CSA) Services

Prevalence Estimate: The national prevalence estimate for North Carolina, as determined by the most recent National Survey on Drug Use and Health, is that 6.57% of adolescents ages 12-17 have a substance abuse problem in any given year.

3.4. Indicators of Timely Initiation and Engagement in Service for Persons Receiving Mental Health and Substance Abuse Services

Rationale: Timely assessment and initiation of appropriate, ongoing service is critical to protect consumer health and safety, minimize adverse consumer events, and promote positive consumer outcomes.

3.4.1. Initiation of Services for Persons Receiving Mental Health Services

3.4.2. Initiation of Services for Persons Receiving Substance Abuse Services

Performance Standard: The percent of persons in each disability group who receive at least two services in the first 14 days of a new episode of care is equal to or above the statewide average for the reference period from the previous fiscal year.

Measurement: The DHHS shall calculate quarterly the time between the first and second service events (assessment and/or treatment) for each consumer starting a new episode of care, based on IPRS and/or Medicaid paid service claims data, to determine the percent of new consumers who received at least two services in the first 14 calendar days of care. A new episode of care is defined by having no state- or federally-funded claim-based service, except for medication management, for at least 60 days.

3.4.3. Engagement in Services for Persons Receiving Mental Health Services

3.4.4. Engagement in Services for Persons Receiving Substance Abuse Services

Performance Standard: The percent of persons in each disability group who meet the initiation criteria and receive at least two additional services in the following 30 days of care is equal to or above the statewide average for the reference period from the previous fiscal year.

Measurement: The DHHS shall calculate quarterly the time between the second and fourth service events (assessment and/or treatment) for each consumer who received a second service within the first 14 days of care (i.e. consumers who met the standard for Initiation of Services (Measures 3.4.1 and 3.4.2), based on IPRS and/or Medicaid paid service claims data, to determine the percent of consumers starting a new episode of care who met the timely initiation measure and received at least two additional services in the next 30 calendar days of care.

3.5. Timely Support for Persons with Intellectual or Developmental Disabilities

Rationale: Timely assessment of need and connection to adequate supports is critical to protect consumer health and safety, minimize adverse consumer events, and promote positive consumer outcomes.

Performance Standard: The percent of persons with intellectual or developmental disabilities who receive a single billable service for within 30 days of an initial screening for a new episode of routine care is equal to or above the statewide average for the reference period from the previous fiscal year.

Measurement: The DHHS shall calculate quarterly the time between the initial screening date for routine services, based on CDW Screening Record data, and the date of the first billable service, based on IPRS and/or Medicaid paid service claims data, to determine the percent of new consumers who received a billable service within the first 30 calendar days of care. A new episode of care is defined by having no state- or federally-funded claim-based service, except for medication management, for at least 60 days.

3.6. Crisis and Inpatient Service Indicators

3.6.1. Appropriate Psychiatric Hospital Use

Rationale: Serving individuals in crisis in the least restrictive setting and as close to home as is appropriate helps families to stay in touch and participate in the individual's recovery and reserves high-cost psychiatric hospital beds for individuals in need of more intensive, long-term care. This is a Mental Health Block Grant measure required by the federal Center for Mental Health Services (CMHS).

3.6.1.1. Short Term Care in State Psychiatric Hospitals

Performance Standard: The percent of persons with stays in a state psychiatric hospital for seven days or less is equal to or below the statewide average for the reference period from the previous fiscal year.

Measurement: The DHHS shall calculate the lengths of stay of individuals discharged from a state psychiatric hospital each quarter, as recorded in the Healthcare Enterprise Accounts Receivable Tracking System (HEARTS) to determine the number of individuals with lengths of stay of 1-7 days as a percent of all discharged individuals for the quarter.

3.6.1. Psychiatric Hospital Readmissions

Rationale: Individuals who receive appropriate community-based services following inpatient care attain a more stable recovery and experience fewer crises and hospital readmissions. An individualized crisis plan, developed through person-centered planning, can help to prevent crises and ensure that crises that do arise can be addressed without further hospitalization. This is a Mental Health Block Grant measure required by CMHS.

3.6.1.1. Hospital Readmissions within 30 Days

3.6.1.2. Hospital Readmissions within 180 Days

Performance Standard: The percent of persons readmitted to a state psychiatric hospital within the designated days of discharge is equal to or below the statewide average for the reference period from the previous fiscal year.

Measurement:
The DHHS shall calculate the number of individuals who are readmitted to a state psychiatric hospital within 1-30 days and 1-180 days of discharge as a percent of all individuals discharged from a state psychiatric hospital each quarter, as recorded in HEARTS.

3.6.1.3. Community Hospital Readmissions within 30 Days

Performance Standard: The percent of Medicaid recipients readmitted to a community psychiatric hospital within 1-30 days of discharge. SFY 2012 will be used as a reference to set a benchmark for performance in future years.

Measurement:
The DHHS shall calculate the number of Medicaid recipients who are readmitted to a community psychiatric hospital within 1-30 days of discharge as a percent of all Medicaid recipients discharged from a community psychiatric hospital each quarter, as recorded in Medicaid paid claims data.

3.7. Continuity of Care Indicators

Rationale: Timely follow-up care is critical to minimize adverse consumer outcomes, prevent the need for re-hospitalization, and promote recovery.

3.7.1. Follow-Up after Discharge from a State Psychiatric Hospital

3.7.2. Follow-Up after Discharge from a State Alcohol and Drug Abuse Treatment Center

Performance Standards: The percent of persons discharged from (1) state psychiatric hospitals and (2) ADATCs who receive a community-based service within seven days is equal to or above the statewide average for the reference period from the previous fiscal year.

Measurement: The DHHS shall compare quarterly each consumer's date of discharge from a state psychiatric hospital or ADATC, as recorded in HEARTS, to the consumer's first date of service (assessment and/or treatment) paid through an Integrated Payment & Reporting System (IPRS) and/or Medicaid service claim to determine the number of persons who received a community-based service within 7 days of discharge as a percent of all persons discharged during the quarter.

3.7.3. Follow-Up after Discharge from a Community Psychiatric Hospital Bed

Performance Standard: The percent of persons discharged from a community psychiatric hospital bed who receive a community-based or state facility service within seven days is equal to or above the statewide average for the reference period from the previous fiscal year.

Measurement: The DHHS shall compare quarterly each consumer's date of discharge from a community psychiatric hospital or psychiatric unit of a general hospital to the consumer's next date of service (assessment and/or treatment), based on an Integrated Payment & Reporting System (IPRS) and/or Medicaid service claim or state facility admission in HEARTS, to determine the number of persons who received a service within seven days of discharge as a percent of all persons discharged during the quarter.

3.7.4. Follow-Up after Discharge from a Community Crisis Service

Performance Standard: The percent of persons discharged from a community-based crisis service who receive a community-based or state facility service within five calendar days is equal to or above the statewide average for the reference period from the previous fiscal year.

Measurement: The DHHS shall compare quarterly each consumer's date of discharge from facility based crisis, or non-hospital medical detoxification, to the consumer's next date of service (assessment and/or treatment), based on an Integrated Payment & Reporting System (IPRS) and/or Medicaid service claim or state facility admission in HEARTS, to determine the number of persons who received a service within 5 calendar days of discharge as a percent of all persons discharged during the quarter.

3.7.5. CCNC Medical Care Coordination

Performance Standard: The percent of Medicaid recipients in Quadrants II and IV (See Section 7.3.4.) with at least one visit to a CCNC/primary care physician per year. SFY 2012 will be used as a reference to set a benchmark for performance in future years.

Measurement: The DHHS shall calculate the number of Medicaid recipients who received a primary care service from a CCNC physician in the most recent 5 quarters as a percent of Medicaid recipients who received a MH/DD/SA service during the most recent quarter, as recorded in Medicaid paid claims data (lagged 3 months).

Attachment III
FINANCING

1.0 Systems Management Funding

The LME shall be paid a monthly allocation for LME-MCO administrative functions. The administrative funding is determined from the total of the LME-MCOs' State and Federal Community Service's funding allocation times fourteen percent (14%). The fourteen percent (14%) funding amount must be applied as follows.

- The LME-MCO can use up to twelve percent (12%) of this allocation for administrative functions.
- The LME-MCO must set aside two percent (2%) of the administrative funding in a separate account titled State Fund Risk Reserve. The reserve account will be maintained by the LME-MCO to offset possible liabilities for State funded services. The account should have at all times a balance of at least fourteen percent (14%) of the total State and Federal community service funding received by the LME-MCO. Any excess funds should be applied to community services.

The Waiver Systems Management funding, payment and rate will be determined by the Division with periodic reviews and adjustments. If a county chooses to provide additional funding for Systems Management functions, such additional funding must be in addition to the funding required of counties by G.S. 122C-115.

The Waiver Systems Management payment will cover but is not limited to the following LME-MCO functions which are more fully described in the Scope of Work.

(1) General Administration and Governance;
(2) Business Management and Accounting;
(3) Information Management Analysis and Reporting;
(4) Claims Processing;
(5) Provider Relations and Support;
(6) Access, Screening, Triage and Referral;
(7) Service Management (Utilization Management, Service Coordination and Community Collaboration);
(8) Consumer Affairs and Customer service;
(9) Quality Improvement and Outcomes Evaluation.

1.1 Expansion or Reduction in Funding:

In the event the Division receives an expansion in state appropriated funding and/or an increase in federal funding for community MH/DD/SA services, or if the state or federal funding is reduced, the state and federal allocation may be adjusted in accordance with the formula used for all other LME-MCO's.

1.2 Additional Equity Adjustments:

State and federal funds may be adjusted in accordance with the plan implemented by the Division to adjust allocations to all LME-MCOs to distribute funding more equitably.

1.3 State Hospital Resource Adjustments:
The Department of Health and Human Services may determine if any adjustments in funding from the State Facilities will be made.

1.4 Administrative Limits:
The following limits apply to funding for LME-MCO Administrative activities as outlined in section 1.0.to be fourteen percent (14%) of total State and Federal Community Service funding. An LME-MCO administrative cost report maybe required. The LME-MCO is responsible for covering administrative cost related to management of state and federal services within the approved percentage rate. .

2.0 Services Funding

2.1 Settlement for Service Funding:
The Division will provide additional guidance for the year end settlement process. For the purpose of settlement of service funds, service funds are defined as all payments from DMHDDSAS to the LME-MCO, less fourteen percent (14%) of such amount for administration as set forth in Section 1.4, Administrative Limits, above.

*An “allowable IPRS shadow claim” is defined as a claim submitted each checkwrite to the Integrated Payment and Reporting system (IPRS) and processed successfully to render a single stream funded claim [EOB 8586] . (IPRS will be eventually replaced by NCTracks the new MMIS system so name and terminology subject to change.)

2.2 Utilization for State Facilities:
The LME-MCO will submit to the Department annually by March 1, of each year, a plan for the LME-MCO’s utilization of State facilities, by bed type, for the upcoming fiscal year.

The LME-MCO Director shall serve as the Division Director’s designee in approving admission to State psychiatric hospitals in accordance with G.S. 122C-261(f)(4), the Thomas S. Diversion Law. In so doing, the LME-MCO Director shall ensure every effort has been made to identify an appropriate alternative treatment location prior to approving the admission to a state psychiatric hospital.

3.0 Single Stream Funding

An LME-MCO that is approved by DHHS to receive single stream funding shall be required to follow the DMH/DD/SAS's most currently published standards for single stream funding initial qualifications, continuing designation, removal, and reinstatement following removal. These standards are published on the DMH/DD/SAS's web site.

An LME-MCO that is approved by DHHS to receive single-stream funding shall continue to enroll individuals into the appropriate population group and to report service units to

the Integrated Payment and Reporting System (IPRS)) or any additional system directed by the Division.. Reporting to IPRS shall contain accurate and complete content to allow either (a) claims payment through the appropriate source of Federal funds not included in single-stream funding or (b) processing of claims via submission of shadow claims data to achieve an EOB 8586 Single Stream Funding Claim.

Except as noted herein, an LME-MCO that receives single-stream funding shall use DMH/DD/SAS funding only to purchase services included in the IPRS service array. If the LME-MCO desires to provide services not included in the IPRS service array, the LME-MCO shall submit the LME-MCO Alternative Service Request for Use of DMH/DD/SAS State Funds as outlined in the DMH correspondence to LME-MCO Directors dated April 22, 2008.

Each LME-MCO receiving single stream funding shall meet or exceed the DMH designated Maintenance of Effort (MOE) requirements for state only funding by LME-MCO for SFY 11-12 in accordance with the DMH/DD/SAS's LME-MCO baseline levels of SFY funding amounts of the substance abuse and mental health state funds that were being allocated to the LME-MCO in the designated base year immediately prior to the LME-MCO's entrance into single stream funding.

Required expenditures by LME-MCO of state appropriated funds for substance abuse treatment services shall be reported in IPRS and shall fully address both the overall SAPTBG MOE for substance abuse treatment expenditures and the Women's MOE for substance abuse treatment expenditures for pregnant women and women with dependent children.

Required expenditures by LME-MCO of state appropriated funds for mental health treatment services shall be reported in IPRS and shall fully address both the overall MHBG MOE for mental health treatment expenditures and the Child Mental Health Services MOE for mental health treatment expenditures for children and adolescents under the age of 18.

The DMH shall pay LMEs operating under single-stream funding 1/12th of the allocated state funds for the month subject to cash availability. Subsequent payments shall be made in accordance to the following plan

Payment Plan Methodology

- The Division will review 1st and 2nd qtr shadow claim data for all LMEs
- Compare shadow claim earnings of what would have paid vs 1/12th monthly payment due to LMEs
- LMEs must earn in IPRS claims and Non UCR expenses an amount equal to or greater than the Division's 1/12th payments for the 1st qtr (July thru Sept) before releasing next payment.
- The next payment will be paid based on the difference in the reported earnings and 1/12th payments made. (October payment).

Examples of funding process calculation:

First example

If the LME received the following; a total annual based allocation of $12,000,000.

Single stream payments for July through September totaled	$3,000,000
Less: Reported IPRS claims (Shadow Claims) July through September	$1,500,000
Less: Reported Non UCR expenses for July through September	$ 500,000
Total remaining	$1,000,000

The LME would not be eligible to receive a payment for October. This is due to the reported claims and expenses incurred are less than the funds disbursed for the 1st qtr. The reported claims and expenses for October would determine the next payment amount, based on actual claims and expenses reported..

Second example

If the LME received the following; a total annual based allocation of $12,000,000.

Single stream payments for July through September totaled	$3,000,000
Less: Reported IPRS claims (Shadow Claims) July through September	$2,500,000
Less: Reported Non UCR expenses for July through September	$ 500,000
Total remaining	$ 0

The LME is eligible to receive a service fund payment for October. Because the reported claims and expenses for the 1st qtr is greater than or equal to the funds disbursed for the 1st qtr. The payment amount would be the amount of the October single stream payment.

For the purpose of settlement, an allowable IPRS shadow claim is defined as an IPRS claim which processes to render a budget/fiscal deny [EOB 8505].

The Division will perform a settlement process for each year with anticipated date of completion by December 31 of each year, subject to adjustment, as necessary, based upon the LME's final audit.

4.0 Reservation of Funds for Utilization in Subsequent Fiscal Years

4.0.1 This section applies only to multi-county LME-MCOs and not single county programs

4.0.2 Funds otherwise required to be reserved by North Carolina General Statutes or as otherwise determined by the independent auditor, do not require prior approval from DHHS and are not impacted by items 4.0.3 and 4.0.4 below.

4.0.3 The portion of fund balance that is designated by the Area Board may be excluded in the DHHS determination of the 15% unrestricted fund balance. To be excluded, such designation must first be approved by the Area Board and then the

LME-MCO must have secured approval from the DMH/DD/SAS for the designation. Prior approval is to be requested in writing to the DMH/DD/SAS, Financial Operations. DMH/DD/SAS shall respond in writing to the LME-MCO within thirty (30) days after receipt of the request. At a minimum, requests submitted by LME-MCOs to the DMH/DD/SAS shall include: (i) amount of funds requested for designation by purpose, (ii) a detailed justification for the proposed utilization of the funds requested for designation by purpose, including a timetable for expending the designated funds, (iii) impact analysis, by purpose, if the request(s) to designate funds is not approved by the DMH/DD/SAS, and a copy of the LME-MCO Board minutes which reflect the Board's approval to request the designation of such funds. Such requests for designation must be submitted to the DMH/DD/SAS prior to the June 15 of the year in which the funds are available for designation to allow review and action prior to fund balance computations for the year.

4.0.4 In the event the unrestricted fund balance for any year is in excess of the fifteen percent (15%) which the LME-MCO may retain, the fund balance amount above 15% is to be handled in accordance with 10A NCAC 27A .0111.

5.0 Disallowances

Any funds or part thereof transferred by DHHS to the LME-MCO shall be subject to reimbursement by the LME-MCO to DHHS in the event those funds are disallowed pursuant to a State or federal audit.

6.0 Restrictions on the Expenditure of Substance Abuse Prevention and Treatment Block Grant (SAPTBG) Funds and Community Mental Health Services Block Grant (CMHSBG) Funds

CMHSBG and SAPTBG funds are prohibited to be used to provide or purchase inpatient hospital services, except for SAPTBG funds may be used with exception as described in 45 CFR 96.135 (c)*.

CMHSBG and SAPTBG funds are prohibited to be used to make, or to allow to be made, any cash payments to any recipients or intended recipients of health or MH/DD/SA services.

CMHSBG and SAPTBG funds are prohibited to be used to make, or to allow to be made, any cash payments to any recipients or intended recipients of health or MH/DD/SA services.

CMHSBG and SAPTBG funds are prohibited to be used for the purchase or improvement of land, purchase, construction or permanent improvement (other than minor remodeling) of any building or other facility, or purchase of major equipment, including medical equipment.

CMHSBG and SAPTBG funds are prohibited to be used to satisfy any requirement for the expenditure of non-Federal funds as a condition of receipt of Federal funds. (i.e. Federal funds may not be used to satisfy any condition for any state, local or other funding match requirement).

CMHSBG and SAPTBG BG funds are prohibited to be used to provide financial assistance to any entity other than a public or nonprofit private entity.

CMHSBG and SAPTBG funds are prohibited to be used towards the annual salary of any LME-MCO, provider, or contractor employee, consultant, or other individual that is in excess of Level I of the most current US Office of Personnel Management federal Executive Salary Schedule. This amount is currently designated for calendar year 2010 at an annual salary of $199,700.

SAPTBG funds are prohibited to be used to provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs

SAPTBG funds are prohibited to be used to provide individuals with treatment services in penal or correctional institutions of the State (This includes jails, prisons, adult and juvenile detention centers, juvenile training schools, etc.)

PATH formula grant funds shall not be expended on:

a. to support emergency shelters or construction of housing facilities;
b. for inpatient psychiatric treatment costs or inpatient substance abuse treatment costs; or
c. to make cash payments to intended recipients of mental health or substance abuse services.

* Note Exception for substance abuse inpatient hospital services under the SAPTBG is as follows:

45 CFR Part 96.135 (c) Exception regarding inpatient hospital services.

(3) With respect to compliance with the agreement made under paragraph (a) of this section, a State (acting through the Director of the principal agency) may expend a grant for inpatient hospital-based substance abuse programs subject to the limitations of paragraph (c)(2) of this section only when it has been determined by a physician that:
   a. The primary diagnosis of the individual is substance abuse, and the physician certifies this fact;
   b. The individual cannot be safely treated in a community-based, nonhospital, residential treatment program;
   c. The Service can reasonably be expected to improve an individual's condition or level of functioning;
   d. The hospital-based substance abuse program follows national standards of substance abuse professional practice; and

(4) In the case of an individual for whom a grant is expended to provide inpatient hospital services described above, the allowable expenditure shall conform to the following:
   a. The daily rate of payment provided to the hospital for providing the services to the individual shall not exceed the comparable daily rate provided for community-based, nonhospital, residential programs of treatment for substance abuse; and
   b. The grant may be expended for such services only to the extent that it is medically necessary, i.e., only for hose days that the patient cannot be safely treated in a residential, community-based program.

ATTACHMENT IV

Informatics Center System Access Agreement

This Informatics Center System Access Agreement ("Agreement") is made effective this ____ day of _____, 20___ (the "Effective Date"), by and between _____, a _____ organized under the laws of the State of _____ and having its principal place of business at _____ ("Network"); and _____, a _____ organized under the laws of the State of _____ and having its principal place of business at _____ ("Provider") (each, a "Party" and together, "Parties").

WHEREAS, Pursuant to its authority under N.C.S.L. 1991-900, N.C.S.L. 1997-443, and Section 1915(b) of the Social Security Act, the North Carolina Department of Health and Human Services, Division of Medical Assistance ("Medicaid") has implemented managed care and primary care case management programs for North Carolina Medicaid beneficiaries, and has been directed by the North Carolina General Assembly, pursuant to N.C.S.L. 2002-126, to monitor and assess the cost-effectiveness of such programs; and

WHEREAS, Medicaid has contracted with North Carolina Community Care Networks, Inc. ("NCCCN") to establish and maintain an electronic patient data exchange system known as the "Informatics Center" (as further described below), which will be used, among other purposes, to permit electronic access to health information about Beneficiaries (as defined below) in connection with the Medicaid health care quality initiative programs described herein; and

WHEREAS, Network participates in one or more of such programs, and as part of its participation, performs certain administrative functions on behalf of Medicaid, and exchanges electronic information through the Informatics Center in compliance with applicable State and federal law, including without limitation, the federal Health Insurance Portability and Accountability Act of 1996 and its implementing regulations on privacy and security found at 45 C.F.R. Parts 160 and 164 ("HIPAA"), the federal restrictions upon the disclosure and use of drug and alcohol abuse patient records as authorized by Section 523 of the federal Public Health Service Act which is codified at 42 U.S.C. 290dd-3 and 290ee-3 and its implementing regulations as found in 42 C.F.R. Part 2 the Confidentiality of Alcohol and Drug Abuse Patient Records and the HITECH Act, as applicable to Network and as the same may be amended from time to time; and

WHEREAS, Provider wishes to access the Informatics Center for purposes of providing patient care, or conducting quality assessment and improvement activities, including case management or care coordination, in connection with one or more health care quality initiative programs sponsored by the Community Care of North Carolina program or the North Carolina Department of Health and Human Services; and

WHEREAS, Provider has an authorized relationship with the Medicaid Program to promote the health care of its Beneficiaries and to facilitate providing such services when Medicaid desires that there be an exchange of electronic information through the Informatics Center in compliance with the terms and conditions of this Agreement and with applicable State and federal law, including without limitation, HIPAA 42 C.F.R. Part 2 the Confidentiality of Alcohol and Drug Abuse Patient Records, and the HITECH Act, as applicable to Provider and as the same may be amended from time to time.

NOW, THEREFORE, in consideration of the foregoing premises and the mutual covenants and agreements set forth below, and other good and valuable consideration, the receipt and legal sufficiency of which are hereby acknowledged, and wishing to be legally bound hereby, the Parties hereto agree as follows:

1. Definitions.

a. "*Authorized User*" means Provider's employees, agents, assigns, representatives, independent contractors, or other persons or entities authorized by Provider to access, use or disclose information from the Informatics Center subject to the terms of this Agreement.

b. "*Beneficiary*" means any individual for whom Medicaid has been officially or statutorily mandated to conduct health care quality initiative programs.

c. "*Confidentiality Agreement*" means an agreement between Provider and one or more Authorized Users that includes appropriate restrictions on information access and disclosure, including means for protecting personal privacy and Proprietary Information (as defined below).

d. "*Data*" includes electronic information relating to health care services provided to Beneficiaries under Medicaid's health care quality initiative programs, including without limitation PHI and PII. For avoidance of doubt, Data shall not include information about a Beneficiary's eligibility to receive Medicaid coverage.

e. "*HIPAA*" has the meaning set forth in Section 2 below and "42 C.F.R., Part 2, the Confidentiality of Alcohol and Drug Abuse Patient Records" has the meaning set forth in Section 2 below.

f. "*Informatics Center*" means that software, portal, platform, or other electronic medium furnished by NCCCN on behalf of entities that include but are not limited to Medicaid as a means to permit electronic access to health information about individuals that include but are not limited to, Beneficiaries in connection with the Medicaid health care quality initiative programs described herein.

g. "*PHI*" means electronic "protected health information" (as that phrase is defined in 45 C.F.R. § 160.103 of the HIPAA regulations, or any subsequent amendments thereto) about Beneficiaries.

h. "*PII*" or "personally identifiable information" means electronic information that identifies or may be used to identify an individual, including without limitation first name or first initial and last name in combination with address, driver's license number, credit card number or Social Security number.

i. "*Proprietary Information*" means all information marked as "proprietary," "confidential" or with other similar designation and all information that by the nature or the circumstances surrounding its disclosure should reasonably be regarded as confidential or proprietary, but excluding Data.

j. "*Security Incident*" means a successful unauthorized access, use, disclosure, modification, or destruction of Data, or interference with the operations of Provider's System, of which Provider has knowledge or should, with the exercise of reasonable diligence (i.e., no less than as required by applicable laws and regulations), have knowledge, excluding (i) pings on Provider's System firewall; (ii) port scans; (iii) attempts to log on to Provider's System or enter a database with an invalid password or user name; (iv) denial-of-service attacks that do not result in a server being taken offline; or (v) malware (e.g., worms or viruses), that do not result in unauthorized access, use, disclosure, modification, or destruction of Data.

k. "*State*" means any state of the United States, the District of Columbia, the Commonwealth of Puerto Rico, and any territory or possession subject to the legislative authority of the United States.

l. "*System*" means software, portal, platform, or other electronic medium controlled or utilized by Provider, through which or by which Provider exchanges information under this Agreement. For purposes of this definition, it shall not matter whether Provider controls or utilizes the software, portal, platform or other medium through ownership, lease, license, or otherwise.

2. Scope of this Agreement. Network and NCCCN have previously executed a Network System Access Agreement obligating the parties to protect the confidentiality and security of Data in accordance with applicable State and federal law, including without limitation, the federal Health Insurance Portability and Accountability Act of 1996 and its implementing regulations on privacy and security found at 45 C.F.R. Parts 160 and 164 ("HIPAA"), and 42 C.F.R. Part 2, the Confidentiality of Alcohol and Drug Abuse Patient Records, and the Health Information Technology for Economic and Clinical Health (HITECH) Act, Pub. L. No. 111-5, Title XIII (2009), Section 1902(a)(7) of the Social Security Act which provides for safeguards which restrict the use or disclosure of information concerning Medicaid or CHIP beneficiaries to purposes directly connected to the administration of the Medicaid or the CHIP programs, and regulations found at 42 C.F.R. § 431.302, which specify the purposes directly connected to the administration of the Medicaid or the CHIP programs, and the mental health information confidentiality provisions found in the North Carolina Mental Health, Developmental Disabilities, and Substance Abuse Act of 1985, as codified in Article 3 of Chapter 122C of the North Carolina General Statutes, as applicable to the parties and as the same may be amended from time to time, the terms of which agreement require that Provider agree to the terms and conditions hereunder prior to providing Data to or accessing Data from the Informatics Center.

3. Use of and Access to Data.

a. **Permitted Uses and Disclosures**. Subject to the terms and conditions of this Agreement, Provider may use Data obtained from the Informatics Center (by or on its behalf) solely for those purposes outlined in the Scope of Work incorporated into the agreement between the Network and Medicaid to participate in a Community Care of North Carolina (CCNC) Program, a form of which is attached hereto as Exhibit 1 ("SOW"), or as authorized in that certain authorization memorandum issued by Medicaid, a form of which is attached hereto as Exhibit 2 ("Authorization Memorandum"), and disclose or permit access to such Data solely to Authorized Users solely for the purposes outlined in the SOW or Authorization Memorandum, or as otherwise expressly authorized in writing by Medicaid. Data disclosed by Provider into the Informatics Center (whether by or on behalf of Provider) may be used for those purposes outlined in that certain Memorandum of Agreement executed between Medicaid and NCCCN as of December 23, 2008, as amended from time to time ("Memorandum of Agreement"), the Authorization Memorandum, or as otherwise expressly authorized in writing by Medicaid.

b. **Authorized Users**. Provider shall identify, and provide upon reasonable request the names of, those persons (or entities, if names of individual persons are not reasonably practicable to provide at the time of such request) that are its Authorized Users for purposes of this Agreement. Provider shall use reasonable care in selecting such individuals and shall place appropriate privacy and security restrictions on its Authorized Users. Provider shall apply appropriate sanctions against Authorized Users that fail to comply with the requirements of this Agreement, and immediately terminate an Authorized User's access to Data when they no longer qualify as an Authorized User. Provider will be responsible for initiating, updating, monitoring, controlling and removing or suspending access of its Authorized Users in accordance with the law and any requirements contained in this Agreement, including but not limited to Section 5. Before allowing access to the Informatics Center, or use or disclosure of Data to an Authorized User, Provider shall require such Authorized User to agree to a Confidentiality Agreement containing terms for the protection and use of Data and Proprietary Information substantially similar to those contained herein. Provider shall log in an audit trail or otherwise document Authorized User's consent to the Confidentiality Agreement. Provider shall report to Network any breach of this Informatics Center System Access Agreement of which it becomes aware.

c. **Access to Data**. Subject to the terms and conditions of this Agreement, and if mutually agreed to by the Parties, Provider will provide Data to the Informatics Center dating as far back as the information is generally accessible in electronic format and maintained on Provider's System. Subject to the terms and conditions of this Agreement, Data will be available for access by Provider solely in connection with uses authorized by Medicaid in writing. Provider acknowledges that Data is drawn from numerous sources. Certain categories of information, including but not limited to HIV status, mental health records, substance abuse records and genetic information, may be more sensitive and accorded extra protections under State and federal law. For this or other reasons, certain types of Data may not be accessed, used or disclosed hereunder. In addition, Provider agrees to: (i) maintain Data on its System for a time period as established by Provider's internal policies and procedures, but in no event less than that required by applicable law; (ii) provide Data in a timely manner for purposes of this Agreement; and (iii) notify any recipient hereunder in advance of any planned changes to its System that may impact the availability or accuracy of Data. If Provider becomes aware of any material inaccuracies in its own Data or System, it agrees to communicate such inaccuracy to Network as soon as reasonably possible. If Provider is unable reasonably to provide Data due to material inaccuracies, it shall provide a written statement indicating such limitations. In the event Provider or Provider's Authorized Users agree to place additional restrictions on Data, Provider shall be solely liable for maintaining such restrictions. Provider agrees and acknowledges that Provider or NCCCN, as applicable, may assume that, and treat such Data as if there are no additional restrictions placed on such Data except as otherwise stated in this Agreement or required by relevant law.

d. **Ownership**. Disclosure of Data under this Agreement does not change the ownership of Data under applicable State and federal laws. If Data has been used or disclosed for treatment, payment, or health care operations, it may thereafter be integrated into the records of the recipient. This Agreement does not grant either Party any rights in the Informatics Center, Provider's System, or any of the technology used to create, operate, enhance or maintain the System of the other Party.

4. Provider Requirements. Provider, whether providing, receiving or using information hereunder, shall:

a. establish and implement appropriate policies and procedures to prevent unauthorized access, use and disclosure of Data and ensure that such policies and procedures do not conflict with and are not less restrictive than this Agreement, and provide copies of such policies and procedures to Network upon reasonable request;

b. take prompt action in response to any monitoring or auditing of access to Data conducted by Network, and take reasonable steps to pursue, address and mitigate any breach or other privacy or security issues detected by such monitoring and auditing;

c. notify Network, as soon as reasonably possible, of any Security Incident and take all reasonable steps to mitigate harm arising from such incident;

d. make its internal practices, books and records relating to uses and disclosures of Data available to the Secretary of the U.S. Department of Health and Human Services or his/her designee, if necessary to comply with HIPAA or other applicable State and federal law;

e. provide all Authorized Users with appropriate education and training on the requirements of this Agreement; and

f. provide Network with notice of requests for Data by legal action or requests for public records.

5. Provider Privacy and Security Safeguards.

a. Provider will use appropriate administrative, technical and physical safeguards to protect the confidentiality, integrity, and availability of information and to prevent the use or disclosure of Data other than as permitted or required by applicable federal or State law and this Agreement. To that end, the Provider shall: (i) provide appropriate identification and authentication of Authorized Users; (ii) provide appropriate access authorization; (iii) guard against unauthorized access to Data; and (iv) provide appropriate security audit controls and documentation.

b. Provider shall apply appropriate sanctions against any person, subject to the Provider's privacy and security policies and procedures, who fails to comply with such policies and procedures. The type and severity of sanctions applied shall be in accordance with Provider's privacy and security policies and procedures. Provider shall make employees, agents, and contractors aware that certain violations may result in notification by Provider to law enforcement officials as well as regulatory, accreditation and licensure organizations.

c. Provider may, at its discretion, deny access to any person it has reason to believe accessed, used, or disclosed Data other than as permitted under this Agreement.

d. Provider agrees and acknowledges that a minimum standard of privacy and security is required to protect PHI regardless of legal obligations of Provider. As such, regardless of whether or not Provider is a "covered entity" or "business associate" as defined under HIPAA, it shall comply with the requirements of HIPAA as though each were a covered entity under HIPAA except to the extent that Provider is a business associate and complies with the requirements of a valid business associate agreement.

6. Term and Termination.

a. **Term**. The term of this Agreement shall commence as of the Effective Date and shall continue in full force and effect for as long as Provider elects. Either Party may terminate this Agreement without cause by providing thirty (30) days' prior written notice to the other Party.

b. **Immediate Termination**. Either Party shall have the right to immediately terminate this Agreement to comply with any legal order, ruling, opinion, procedure, policy, or other guidance issued, or proposed to be issued, by any federal or State agency, or to comply with any provision of law, regulation or any requirement of accreditation, tax-exemption, federally-funded health care program participation or licensure which (i) invalidates or is inconsistent with the provisions of this Agreement; (ii) would cause Provider to be in violation of the law; or (iii) jeopardizes the good standing status of licensure, accreditation or participation in any federally or State funded health care program, including without limitation Medicare and Medicaid programs.

c. **Termination with Cause**. Notwithstanding any other provision of this Agreement, either Party may terminate its participation in this Agreement if the other Party has materially violated its responsibilities under this Agreement and has failed to provide satisfactory assurances within ten (10) days of notice of such material violation that reasonable steps are being taken to effect a cure, and in any

event: (i) such cure will be completed no later than thirty (30) days from notice of such material violation; and (ii) the breaching Party has taken reasonable steps to prevent the recurrence of such material violation.

d. **Termination of Access to Data**. Notwithstanding subsection c. above and to the extent permitted by law, Network or NCCCN, as applicable, reserves the right to terminate immediately Provider's access to Data at any time if Network has a good faith, reasonable basis reason to believe that Provider has suffered a Security Incident of the security of its System, has violated any material obligations under this Agreement, including without limitation accessing any information that Provider would not otherwise be authorized to receive pursuant to this Agreement, improperly disclosing Data or failing to abide by appropriate policies and procedures.

e. **Remedies for Breach**. Each Party agrees that money damages may not be a sufficient remedy for any breach of this Agreement and that, in addition to all other available legal or equitable remedies, the non-breaching Party will be entitled to equitable relief, including injunction and specific performance, for any breach of the provisions of this Agreement, without proof of actual damages.

f. **Effect of Termination**. Upon termination of this Agreement, Data stored and provided to the Informatics Center by Provider shall no longer be accessible through Provider's System. However, Data that has been disclosed hereunder may thereafter be integrated into the records of the recipient. Following termination of this Agreement, Data shall continue to be subject to the provisions of this Agreement, including, without limitation, provisions regarding privacy and security. Provider shall cooperate with Network in making reasonable and medically appropriate arrangements for the continued care of Beneficiaries as soon as reasonably practicable upon termination of this Agreement.

7. Warranties and Limitation of Liability.

a. EXCEPT AS OTHERWISE SET FORTH HEREIN, THE PARTIES HEREBY DISCLAIM ALL IMPLIED AND EXPRESS WARRANTIES, CONDITIONS AND OTHER TERMS, WHETHER STATUTORY OR COMMON LAW, ARISING FROM COURSE OF DEALING, OR OTHERWISE. NO PARTY WARRANTS THAT THE PERFORMANCE OR DELIVERY OF THE DATA WILL BE UNINTERRUPTED OR ERROR FREE. NO PARTY SHALL BE LIABLE TO ANOTHER PARTY FOR ANY CONSEQUENTIAL, INCIDENTAL, INDIRECT, PUNITIVE, OR SPECIAL DAMAGES SUFFERED BY A PARTY OR ANY OTHER THIRD PARTY. NO PARTY SHALL BE LIABLE FOR ANY DAMAGES ARISING OUT OF OR RELATED TO THE ACTS OR OMISSIONS OF ANOTHER PARTY OR THAT PARTY'S AUTHORIZED USERS IN ACQUIRING, ACCESSING, DISCLOSING OR USING DATA. NEITHER PARTY SHALL BE LIABLE TO THE OTHER FOR DIRECT DAMAGES.

b. Without limiting any other provision of this Agreement, each Party and such Party's Authorized Users shall be solely responsible for all decisions and actions taken or not taken involving patient care, utilization management, and quality management for their respective patients and clients resulting from or in any way related to the use of Data. No Party or Authorized User shall have any recourse against, and each shall waive any claims against, the other Parties for any loss, damage, claim or cost relating to or resulting from its own use or misuse of Data.

8. Proprietary Information. Each party ("Receiving Party") will hold in confidence all Proprietary Information obtained from the other party ("Disclosing Party") in connection with this Agreement and use it only for purposes of this Agreement, provided that these restrictions will not apply to any information that (i) was already known to the Receiving Party without obligation of confidentiality; (ii) is or becomes properly available to the Receiving Party (under conditions which do not restrict further disclosure) from a third party source who did not obtain such information directly or indirectly from the Disclosing Party; or (iii) is or becomes part of the public domain through no fault of the Receiving Party. The Receiving Party will return all such Proprietary Information (including all copies thereof) to the Disclosing Party promptly upon request, provided that the Receiving Party may retain in its confidential files one copy of any written materials for purposes of verifying compliance with this Agreement.

9. Agreement's Compliance with Laws and Regulations. The Parties intend and in good faith believe that this Agreement complies with all federal, State and local laws. The Parties agree and acknowledge that they shall at all times perform all obligations hereunder in compliance with applicable law. If any provision of this Agreement is declared void by a court or rendered invalid by any law or regulation, and if such provision is necessary to effectuate the purposes of this Agreement, this Agreement shall automatically terminate.

10. Insurance. Provider agrees to obtain and maintain in force and effect reasonable policies of liability insurance or self-insurance to insure itself and its employees, agents, and contractors for general liability. Upon reasonable request, Provider shall provide to Network relevant information regarding its policies of insurance including, without limitation, coverage limits.

11. Notices. Any notice or other communication required under this Agreement shall be in writing and sent to the respective addresses of the Parties set forth in the signature lines below, or to such other address as the Parties shall designate in writing from time to time. Notices or communications to or between the Parties shall be deemed to have been delivered: (a) ten (10) business days after deposit in the mail when mailed by first class mail, provided that notice of default or termination shall be sent by registered or certified mail; (b) within five (5) days if sent by established courier service; or (c) when received, if personally delivered.

12. Relationship of Parties. Nothing in this Agreement shall constitute a partnership, joint venture, agency or any other relationship between the Parties other than that of independent contractors.

13. Third-Party Beneficiaries. This Agreement does not and will not create in any natural person, corporation, partnership or other organization other than the Parties any benefits or rights, and this Agreement will be effective only as to the Parties and their successors and permitted assigns.

14. Force Majeure. Notwithstanding any provision hereof to the contrary, in the event of a disruption, delay or inability to complete the requirements of this Agreement due to natural disasters, acts of terror or other similar events out of the control of a Party, the Party shall not be considered in breach of this Agreement.

15. Authority to Sign. The Parties warrant that they have the capacity to enter into and perform the obligations under this Agreement and all activities contemplated herein. Each Party represents and warrants that all corporate and other actions required to authorize it to enter into and perform this Agreement were properly taken.

16. Survival. The respective rights and obligations of the Parties under Sections 1, 3.a., 3.c., 4, 5, 6.f., 7, 8, 10, and 17 of this Agreement shall survive any termination or expiration of this Agreement.

17. General.

a. In the event of a dispute between the Parties arising out of this Agreement: (a) a Party receiving Data will be held liable to abide by its own State and federal law; (b) a Party providing Data will be held liable to abide by its own State and federal law; and (c) if the dispute cannot be resolved, the Parties agree to look to federal common law, including the growing body of law regarding health information exchange. A reference in this Agreement to a section in a federal, State, or local statute, law, or regulation means the section as in effect or as amended.

This Agreement may not be modified, altered, or amended except by written instrument duly executed by, if for Network: [_____]; if for Provider: [_____]. Neither this Agreement nor any part thereof may be assigned or transferred without the prior written consent of the other Party, and any such assignment without such consent shall be void and have no binding effect. This Agreement shall be binding on the Parties, their successors and permitted assigns. No failure or delay by either Party in exercising its rights under this Agreement shall operate as a waiver of such rights or estop enforcement thereof, and no waiver of any breach shall constitute a waiver of any prior, concurrent, or subsequent breach or estop enforcement thereof.

b. Subject to Section 2 above and any HIPAA business associate agreement ("BAA"), or Qualified Service Organization Agreement (QSOA), executed between the Parties, this Agreement sets forth the entire Agreement between the Parties relative to the subject matter hereof. Any representations, promise, or condition, whether oral or written, not incorporated herein shall not be binding upon either Party. In the event of an inconsistency between the provisions of this Agreement and mandatory provisions of applicable State or federal law and regulations, including without limitation, HIPAA, such applicable laws and regulations shall control. Where provisions of this Agreement are different than those of the BAA, but are nonetheless permitted under HIPAA, the provisions of this Agreement shall control. All exhibits attached to this Agreement are incorporated by reference and made a part of this Agreement as if those exhibits were set forth in the text of this Agreement. If any portion of this Agreement shall for any reason be invalid or unenforceable, such portion shall be ineffective only to the extent of such invalidity or unenforceability, and the remaining portions shall remain valid and enforceable and in full force and effect. This Agreement may be executed in any number of counterparts, each of which will be deemed an original as against the Party whose signature appears thereon, but all of which taken together will constitute one and the same instrument.

IN WITNESS WHEREOF, the Parties have caused this Agreement to be signed by their duly authorized representatives as of the Effective Date.

[NETWORK]

By: _____
Its: _____
Address: _____

[PROVIDER]

By: _____
Its: _____
Address: _____

EXHIBIT 1

SCOPE OF WORK

North Carolina Department of Health and Human Services
Division of Medical Assistance
2501 Mail Service Center • Raleigh, N. C. 27699-2501 • Tel 919-855-4100 • Fax 919-733-6608

Beverlyly Eaves Perdue, Governor
Lanier Cansler, Secretary

Craigan L. Gray, MD, MBA, JD, Director

AUTHORIZATION MEMORANDUM NO. 1

FROM: North Carolina Division of Medical Assistance ("Division")

DATE: June 22, 2010

RE: Authorization for Access to the Informatics Center of North Carolina Community Care Networks, Inc.

This memorandum is to clarify the intent of the Division and provide more specificity regarding authorized access to the Informatics Center by providers or entities engaged in the treatment, care management, or related activities on behalf of North Carolina Medicaid Beneficiaries.

A. BACKGROUND

Division has contracted with North Carolina Community Care Networks, Inc. ("NCCCN") to utilize its Informatics Center for purposes of certain health information exchange services related to the Medicaid Program. Pursuant to its authority under N.C.S.L. 1991-900, N.C.S.L. 1997-443, and Section 1915(b) of the Social Security Act, Division has implemented managed care and primary care case management programs for North Carolina Medicaid beneficiaries, and has been directed by the North Carolina General Assembly, pursuant to N.C.S.L. 2002-126 to monitor and assess the cost-effectiveness of such programs.

The exchange of health information will enhance appropriate access to health care, increase service delivery options, and improve the health status of below-income patients, children, seniors, and people with disabilities enrolled in the North Carolina Medicaid Program and the North Carolina Healthy Choice Program. Division and NCCCN have established secure electronic patient data exchange systems to electronically exchange health information, including, and as described in, a body of Informatics Center system access agreements entitled "Health Information Exchange Agreement," "Network System Access Agreement," and "Network User System Access

Agreement," and "Informatics Center System Access Agreement" (collectively, "System Access Agreements" or "SAAs"). Other conforming system access agreements are authorized, so long as they are substantially similar to the SAAs and, for purposes of this memorandum, shall also be considered a "System Access Agreement." That system requires protection of patient privacy and security and controls access to the Informatics Center to authorized personnel for authorized purposes.

Paragraph 3 of each SAA relates to the permitted uses and disclosures of Medicaid data submitted to and held by the NCCCN Informatics Center. Uses and disclosures are limited to (1) those set forth in certain Division documents attached to the SAAs entitled "Memorandum of Agreement" ("MOA") and "Scope of Work," ("SOW") or (2) as expressly otherwise authorized in writing by Division. Some questions have arisen concerning the necessary degree of formal affiliation with the Community Care of North Carolina ("CCNC") Program required by the MOA and SOW in order to access the Informatics Center.

B. WRITTEN AUTHORIZATION

This Authorization Memorandum No. 1 shall be considered written authorization by Division for permitted uses and disclosures pursuant to Paragraph 3.a. of the System Access Agreements, respectively, related to access to data of the Informatics Center.

An organization or provider with an authorized relationship to the Medicaid Program may access information from and disclose information to the Informatics Center upon satisfaction of the following terms and conditions, regardless of whether it has a direct contractual relationship with the CCNC Program:

1. It has a legitimate authorized need to access the information for (a) treatment or (b) quality assessment and improvement activities, or coordination of appropriate and effective Beneficiary care, treatment, or habilitation. Such activities include, but are not limited to, direct patient care, case management and care coordination disease management, outcomes evaluations, development of clinical guidelines and protocols, development of care management plans and systems, population-based activities relating to improving or reducing health care costs, and the provision, coordination, or management of mental health, developmental disabilities, and related services.

2. The relationship with the Medicaid Program must be duly authorized, but may be established through a proper enrollment, contract, or otherwise with Division directly or through one of its designated divisions. Entities may include Local Management Entities ("LMEs"), specialists, hospitals, and health departments.

3. It enters into a System Access Agreement.

4. The scope of such permitted use and disclosure shall be limited to and defined by the particular underlying authorized arrangement for Beneficiary care between the organization or provider and Division.

C. USES AND DISCLOSURES BY OTHERS

This confirms that the NCCCN Informatics Center, and others authorized to access health information through SAAs, may receive, disclose, use, and re-disclose such information from authorized organizations and providers pursuant to policies of the secure health information exchange system, the terms and conditions of the relevant SAAs to which they are a party, and all applicable laws.

D. SAA CONTRACTS ADMINISTERED THROUGH CCNC NETWORKS

Further, the CCNC Network geographically most proximate to the organization or provider are approved to be the lead contact for obtaining execution of the SAA with such organization or provider, even though care may be being provided to a Beneficiary or Beneficiaries not necessarily assigned to that Network.

E. INCLUDE WITH SAAS

NCCCN and Networks are instructed to include, by attachment, if possible, this SAA written authorization with all SAA documents and henceforth, until modified or rescinded, deem this to be an added data use and disclosure written authorization thereunder.

North Carolina Department of Health and Human Services
Division of Medical Assistance
2501 Mail Service Center • Raleigh, N. C. 27699-2501 • Tel 919-855-4100 • Fax 919-733-6608

Beverlyly Eaves Perdue, Governor
Lanier Cansler, Secretary

Craigan L. Gray, MD, MBA, JD, Director

F. INTENT OF AUTHORIZATION

This Authorization Memorandum No. 1 is issued with the intent, and shall be so construed and interpreted, to further develop an infrastructure whereby patient privacy and security rights will continue to be protected while North Carolina Medicaid patient

care will be optimized through health information exchange. Access to the Informatics Center hereunder for authorized purposes shall be considered to be in furtherance of the goals of, and part of, the Community Care of North Carolina Program or other primary care case management programs contracting with the Division. All health information exchange shall continue to be in compliance with all applicable laws and regulations.

Location: 1985 Umstead Drive • Dorothea Dix Hospital Campus • Raleigh, N.C. 27603
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Beverly Eaves Perdue, Governor
Lanier Cansler, Secretary

Craigan L. Gray, MD, MBA, JD, Director

Date: July 30, 2010

To: Craigan L. Gray, MD, MBA, ~~JD~~

From: North Carolina Division of Medical Assistance ("Division")

Subject: NCCCN Authorization Memorandum No. 2

The Memorandum of Agreement between the North Carolina Division of Medical Assistance (the "Division") and North Carolina Community Care Networks, Inc., (the "Contractor") specifically states that the Contractor may "provide reports for the Division for purposes outside of CCNC when specifically requested to do so by the Division and when the Contractor agrees to such request."

The Division hereby requests and authorizes the Contractor to report and distribute Medicaid data to Public Health Departments as permitted under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and its implementing regulations at 45 C.F.R. Parts 160 and 164, Subparts A and E.

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Craigan L. Gray, MD, MBA, JD, Director

MEMORANDUM

TO: North Carolina Community Care Networks, Inc.

FROM: North Carolina Division of Medical Assistance

CC: Community Care of North Carolina Networks

DATE: March 17, 2011

SUBJECT: Authorization Memorandum No. 3 (Revised) – Disclosures of Data from the North Carolina Community Care Networks, Inc. Informatics Center

The North Carolina Division of Medical Assistance (the "Division") has contracted with North Carolina Community Care Networks, Inc. ("NCCCN") to utilize the NCCCN Informatics Center for purposes of certain health information exchange services related to the North Carolina Medicaid program. The Division and NCCCN have established secure electronic health information exchange systems, as described in a body of Informatics Center system access agreements entitled "Health Information Exchange Agreement," "Network System Access Agreement," "Network User System Access Agreement," and "Informatics Center System Access Agreement" (collectively, "System Access Agreements").

Paragraph 3.a. of each System Access Agreement sets forth the permitted uses and disclosures of Data (as defined in the System Access Agreement) obtained from the Informatics Center. For purposes of clarification, Data obtained from the Informatics Center may include Data accessed from the Informatics Center and converted into any other electronic or non-electronic (*i.e.*, paper) form, format, or medium. Uses and disclosures of such Data are limited to (1) those purposes set forth in certain Division documents attached to the System Access Agreement entitled "Memorandum of Agreement" and "Scope of Work," or (2) as otherwise expressly authorized in writing by the Division.

This Authorization Memorandum No. 3 (Revised) shall serve as written authorization by the Division, pursuant to Paragraph 3.a. of the System Access Agreement, for the disclosure of Data accessed from the Informatics Center and converted into any other electronic or non-electronic form, format, or medium, according to the following terms and conditions.

A. An organization, provider, or other entity that is a party to a System Access Agreement (a "Disclosing Entity") may, in the exercise of reasonable diligence, disclose Data accessed from the Informatics Center and converted into any other electronic or non-electronic form, format, or medium, to another organization, provider, or entity (a "Receiving Entity") if:

    1. The disclosure of Data is permitted under applicable state and federal law; and

2. The disclosure of Data is: (a) to the individual who is the subject of the Data or to such individual's personal representative, as such term is defined under 45 C.F.R. § 164.502(g); (b) for purposes of treatment, quality assessment and improvement activities, or coordination of appropriate and effective patient care, treatment, or habilitation; or (c) required under applicable state or federal law with respect to the Disclosing Entity; and

3. The Disclosing Entity obtains, either from the individual who is the subject of the Data or from the Receiving Entity, the individual's written authorization to disclose such Data, if required under applicable state or federal law.

B. Nothing in Paragraph 3.a. of the System Access Agreement shall be construed to restrict disclosures of Data accessed from the Informatics Center by an entity, organization or individual that is a party to a System Access Agreement and is subsequently integrated into a medical record of the individual who is the subject of the Data maintained by or for the Disclosing Entity.

ATTACHMENT V
IMT Purpose and Monitoring Responsibilities

1.0 Purpose

The purpose of the 1915 b/c Waiver is to actualize DHHS and DMHDDSAS's Mission and Vision for North Carolina. The 1915 b/c waiver is based on the principles of Recovery, Self-Determination and Person Centered Planning, and which supports an organized delivery system of services and providers across all funding streams. This waiver will demonstrate an interactive, mutually supportive, and collaborative partnership between State Agencies and the Local Management Entity in the implementation of public policy at the local level.

2. Intra-Departmental Monitoring Team:

The Department will maintain an Intra-Departmental Monitoring Team (IMT) to provide monitoring and oversight of Medicaid and state-funded responsibilities under both the DMA and DMHDDSAS contracts. The IMT will meet a minimum of quarterly, and more often if needed. The IMT will assist the LME-MCO in addressing problems and question in implementing Medicaid and state-funded responsibilities and in achieving goals and performance targets. When problems or deficiencies occur in meeting Reporting Requirements, timeliness of information, and performance on Performance Indicators, the IMT will work with the LME-MCO to understand the reasons for the problems and assist in problem resolution by providing technical assistance. The IMT may require an Action Plan when deficiencies are severe or recurrent or if the LME-MCO fails to address noted deficiencies in a timely manner. The Action Plan will be monitored until the problem is resolved.

Members of the Intra-Departmental Monitoring Team shall include the representation from the following:

DMA:

1. Behavioral Health Policy
2. Waiver Section
3. Finance Management/Budget Management
4. Program Integrity
5. Quality Evaluations and Health Outcomes Unit (QEHO)

DMH/DD/SAS:

1. Best Practice Team
2. Best Practice Team – IDD Member
3. Budget Team
4. LME-MCO Performance Team
5. Regulatory Team
6. Quality Management Team

7. IT Team
8. Advocacy and Customer Service Team

The LME-MCO:

1. Management
2. Finance
3. Operations (Access, Network, Waiver Implementation)
4. Quality
5. others to be identified if needed.

DHHS:

1. Office of the Controller
2. Office of Budget and Analysis

3 Scope of Monitoring Activities:

The Monitoring Team will conduct routine monitoring in order to identify problems, deficiencies, and barriers to desired performance expectations and to develop improvement strategies, determine needs for a Corrective Action Plan, and to monitor any Corrective Action Plan in place:

a. Monitoring and Reporting: timeliness, completeness, data content, Attachment II – Section 1.0
b. Performance Indicators: timeliness, completeness and performance against goals, performance standards, and/or benchmarks. Attachment II – Section 3.0

4 Monitoring Process:

The Monitoring Team will use a Continuous Quality Improvement approach to review of the LME-MCO performance. The Team will routinely review, analyze, and interpret data. The purpose is to discover system performance problems, identify performance barriers, and develop improvement strategies, including Corrective Action Plans. The Team will monitor improvement strategies and Corrective Action Plans to ensure that identified problems are improved. The process is important to document both the challenges and successes of the LME-MCO.

a. The Monitoring Team will meet a minimum of quarterly.
b. A regular agenda will be established identifying expected areas to be addressed:
    i. Performance
    ii. State concerns and questions
    iii. LME-MCO's challenges, barriers and need for assistance
    iv. Project successes
    v. Need for changes, improvements, or Action Plan for Correction

vi. Progress on identified problems or Action Plans of Correction.

c. Minutes will be kept of all meetings.

5 Annual Monitoring Review:

DMA – DMHDDSAS will conduct an Annual Monitoring Review on-site at the LME-MCO. The Monitoring Review will serve the purpose of observing and understanding the LME-MCO's operations for both Medicaid and state-funded duties will provide a review of the following:

a. Compliance with the requirements of the DMHDDSAS contract;
b. Compliance with State and Federal Medicaid requirements;
c. The LME-MCOs compliance with G.S. 122C-112.1;
d. Implementation of the LME-MCO's Waiver Implementation Plan
e. To the extent possible, the review will not duplicate areas assessed by the National Accrediting Body (once LME-MCO accreditation has been achieved).
f. Compliance with requirements and restrictions of the SAPTBG, CMHSBG, SSBG, CASP dollars and their accompanying state MOE requirements, the PATH Program federal formula grant, SPF-SIG, SDFSCA, and other federally funded or designated projects.
g. Compliance with all state and federal laws and regulations.